HOME-HELP SERVICES FOR THE AGING AROUND THE WORLD

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The *International Federation on Ageing* is an association of national, voluntary organizations that either represent the elderly as their advocate and/or provide services to them. It came into existence in late 1973 in recognition of the fact that such organizations had much to learn from one another and needed improved national and international representation.

Above all, these organizations sought an international spokesman for the development of solutions to problems associated with aging. The IFA hopes to fulfill this role and to assist in the transfer and application of knowledge to the practical conditions and problems of aging.

Home Help Services
For
The Aging Around The World

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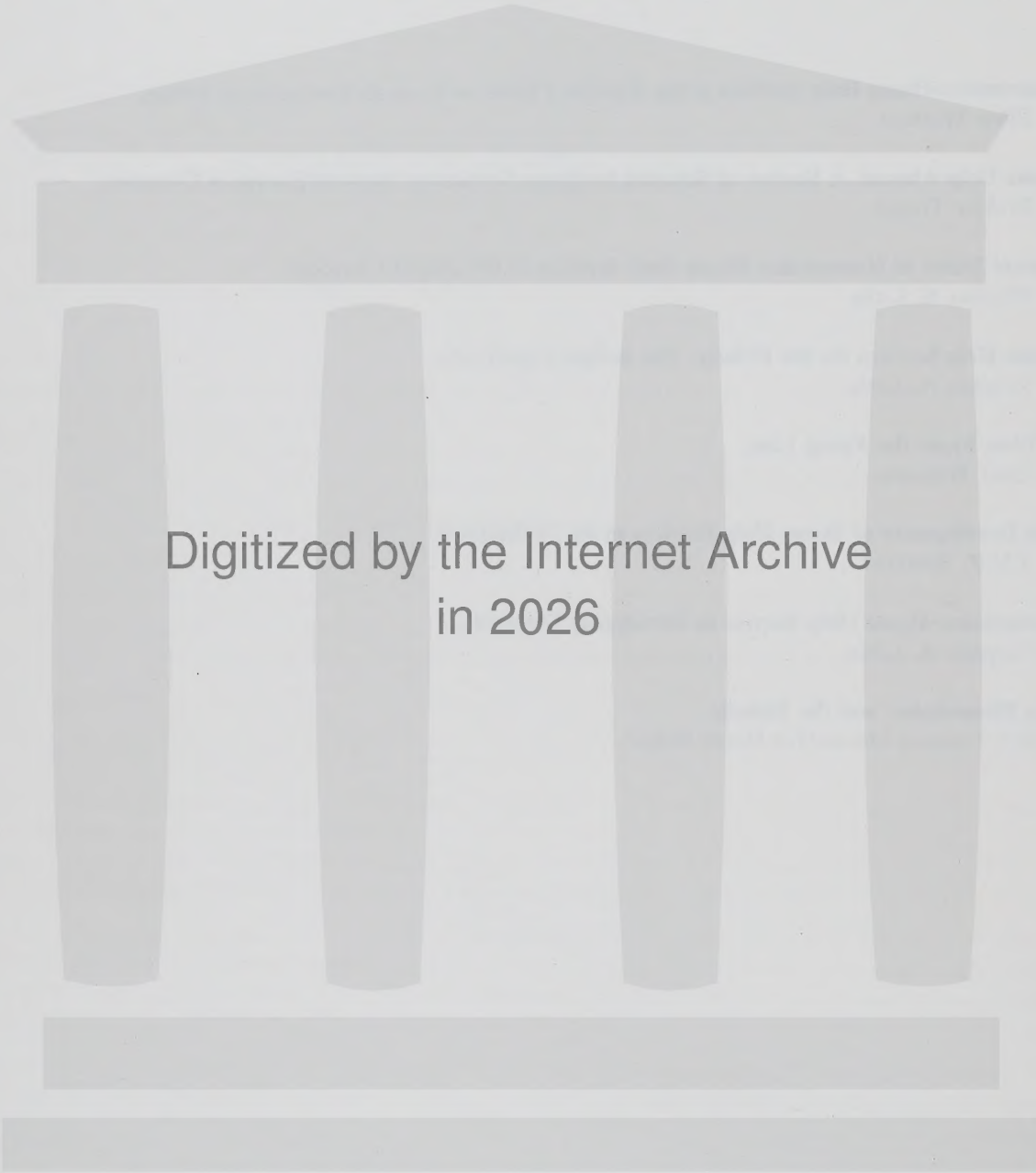
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INTRODUCTION

The increase in both the absolute and relative numbers of the elderly in the world's population has placed great pressure on countries to expand and improve their services to this age group, many of whose members are particularly vulnerable to the physical and social stresses which can come with aging. Trends indicate that over the next 25 years the numbers of persons in the over 75 age group will be considerably larger than it is today. This is also the age group that is most in need of social services. Current pressures on social services can then be expected to accelerate.

One of the basic questions posed to developed nations is what mix of services should be provided between institutional and community care. In many of these countries, where the tradition of the family is strong and great value is placed on maintaining independent living, priority has been placed on improving and expanding home help assistance. Others have provided little alternative to institutional care.

Developing nations will have to face the same issue, aggravated by larger constraints imposed by more limited resources. Yet constraints can call forth considerable untapped creativity and imagination as well.

This volume of articles on home help for the aging examines how various countries have addressed the question of home care for the elderly and their different patterns of development. It also examines the problem of how nations wishing to start or expand home help services may be able to do so within narrow budgets.

We have chosen the issue of home help because most elderly persons in retirement wish to live in their own homes or in more modest and suitable quarters which they have chosen for their later years. It is to their and society's advantage to help them remain in familiar surroundings, among friends and family.

Special impetus was given to produce this work by Dr. Virginia A. Little, Professor of Social Work at the University of Connecticut. She utilized 1973/74 as a sabbatical year for a round-the-world trip visiting and observing more than 100 institutions or agencies providing services to the aging in 20 different countries, as well as some 50 schools of social work and other training facilities. Three articles produced as a result of this study appear in this volume.

Special thanks is also due to Brahna Trager for permitting us to reproduce a chapter from her book *Homemaker/ Home Health Aide Services in the U.S.*, published by the U.S. Department of Health, Education and Welfare. This article was originally copyrighted by the National Council for Homemaker-Home Health Aide Services, Inc. in New York.

Finally, we would like to thank the Homemaker Health Aide Service of the National Capital Area, Inc., Washington, D.C. for permission to excerpt a chapter from its *Training Manual for Homemaker Health Aide Service* on home help to the elderly.

HOMEMAKER-HOME HELP SERVICES TO THE ELDERLY: EFFORTS TO MAINTAIN INDEPENDENT LIVING

by

Ellen Winston

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Around the world, the numbers of older adults are mounting while the traditional ties that have bound families together are weakening. As family responsibility lessens, society is of necessity assuming a widening role.

Where and how older adults, whether the rich or the poor, shall live is a critical question. Central to the question is the fact that most want to remain independent, in their own homes, as long as possible or to return to their own home after periods of hospitalization or other institutional care.

As has been the case in other social and health programs, Western European countries took the lead in developing a practical program to make continued in-home living in the older years of reality, known in those countries as home helps.* In other parts of the world, i.e., Canada, Israel, Japan, the United States, the providers of similar services are known as homemakers. In the United States, because of legislative terminology, home health aide is also a commonly used term. By whatever name, the service is generic, and is basic to both health and social welfare programs. It may be used alone or to undergird one or more additional services. Always, though, the focus is on providing the supportive help, often including some personal care, which is essential to maintaining older persons and older couples in their own homes. Some cooking, some cleaning, some marketing, some laundry are general ingredients with supplementation in individual cases of a tremendous range of large and small aids to maintaining independent living. Increasingly, there is emphasis on teaching older persons how to cope themselves with the requirements of daily living. While the emphasis is on helping to care for the home, the socializing effect of a friendly well-qualified homemaker, whether she comes a day or two a week or five days, for a few hours or for full days, is also a positive contribution to the lonely or isolated older adult. The service is purposely flexible in order to adapt to varying circumstances.

At present, 19 countries have significant programs to help older people remain in their own homes. In most countries there is both public and private financial support. The operating agencies are varied—public, private non-sectarian, private sectarian.** They tend to be administered under local auspices. In some countries the service is normally provided by a single purpose agency; in others it is more often part of a multi-service agency. Increasingly in most countries a team approach is emphasized with the homemaker associated with a social worker, a nurse, a physician, a therapist, a home economist, or whatever professional component is appropriate. In some countries, the homemakers are young women; in others they are more likely to be middle-aged and older women whose children are grown. Some men are used, especially for older men requiring the service. In some countries there is extensive training and supervision, especially of the young women; in others, there is little or no training of the experienced housewives employed and a minimum of supervision. There is a comparable range in the stage of development and enforcement of standards in this still relatively new health and welfare service.

In most European countries the work of the homemaker is considered a prestige occupation. Increasingly, there is emphasis upon special training for the work of the homehelps. Training programs range from a few weeks with the employing agency providing the study course to one or two years of training in residential schools. For example, there were 22 special Homehelp Schools in Germany in 1965 with compulsory training of one year in a school and one year in service training.

Most agencies provide for free service for the poor and fees on a sliding scale for those who can pay. *Increasingly, there is emphasis on inclusion of the service in health insurance provisions*, both as the most appropriate type of care in many cases and as far less expensive care than institutional living.

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* The first Homehelp Association was founded in 1892 in Frankfurt on the Main

** In the United States, at least, there are some proprietary agencies

Homemaker services are provided in most countries with both public and private financial support, and by both public and voluntary organizations. Stemming no doubt from the direct relationship to the needs of individuals in their own homes, often on an emergency basis, they tend to be administered under local auspices even when many other social services are carried out under a more centralized administrative structure. The homemaker may spend only a few hours once a week in a given home or go in for a few hours several times a week for a full day or under some situations be in a home on a twenty-four hours a day basis.

Numbers reflect the growth of the services—over 70,000 homehelps in the United Kingdom with over 80 percent of them serving the elderly; 25,000 homehelps in Norway for families with children as well as the aged. The Netherlands reports over 40,000 part-time homehelps for the care of the aged. A rough measure of adequacy for the older segment of the population is one homemaker for every 100 persons 65 years of age and over. On such a scale the United States, with an estimated 30,000 homemakers and home health aides at present for all types of cases, should have over 200,000 homemakers to adequately meet the needs of older adults alone!

Increasingly, there is a trend toward identifying other services which are supportive of independent living. They may be supplementary to homemaker service or provided independently, on a regular schedule or as needed. High on this list is home maintenance services, sometimes called chore services, usually provided by a man. Various types of meals programs provided in homes or in group settings; telephone reassurance or other methods for a daily check on older people living alone; and friendly visiting are illustrative of such services. Many can be provided by volunteers under a well-developed plan for recruitment, placement, and supervision. Thus, there is both a range of in-home services and a gamut of interrelated personnel—professional, nonprofessional, volunteer—who must be coordinated to achieve the goal of providing for every older adult the option of independent living in his own home to the maximum extent possible.

Four international conferences have been held by the International Council of Homehelp Services*—in Paris in 1962; in Koenigstein, Germany in 1965; in Brussels in 1969; and in London, May 5–11, 1973. Besides these conferences, increasing emphasis is being given to homemaker services on the programs of the biennial conferences of the International Council on Social Welfare. It is encouraging to see this vital service, still new in many countries, still to be initiated in many others, attaining increased stature in the world-wide social welfare community.

While homemaker services must be described in over-all terms, the real test of their significance is the impact on the daily lives of older adults. Think what it means to be able to avoid breaking up one's home and going into some kind of group living because a homemaker is available; or what it means to be able to leave a hospital or nursing home when intensive care is no longer necessary; or to remain in a family group even though the younger adults are employed full time. The illustrations are legion. At long last we are recognizing that the "down-to-earth," useful services of a homemaker hold the key to the continued independent living so desired by and so desirable for literally millions of older adults around the world.

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* Founded in The Netherlands in 1959

HOME HELP ABROAD: A REVIEW OF SELECTED IN-HOME SERVICES IN WESTERN EUROPEAN COUNTRIES*

by

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Health Care Consultant

European programs providing *home help—homemaker-home health aide* services—differ from country to country with respect to auspices, training, patterns of service and emphasis on selected population groups. However, they are alike in one respect: the keen interest which is expressed by government in the development, maintenance and expansion of the services.

This interest may be attributed to a variety of causes. Home help programs in Europe have a longer history than those in the United States. The first program in Europe to provide services in the home was organized in Frankfurt in 1892, and was followed by a similar program in London in 1897. These services developed under voluntary auspices—usually religious—and over a period of time demonstrated their potential value. European interest in the family and the preservation of family life is deeply embedded in cultural attitudes; and this interest is expressed in many aspects of social planning. In general, there is less interest in institutional solutions to problems of illness and family crisis, due largely to this family-centered culture, and probably incidentally, to economic considerations—although the financial aspect does not appear to be a primary consideration.

The effects of two wars on the populations of European countries has also been a major influence, especially in terms of the effects on children. Particularly on the continent, a strong philosophy with respect to sound child rearing practices resulted and stimulated interest in direct approaches: the entry into the family unit of trained personnel to support healthy patterns of child care.

In addition, many of the changes in living patterns that confront Americans are also occurring abroad—increased mobility threatens family unity and the extended family is less available in periods of crisis. Concurrently, there has been the rapid growth of an aging population—and with it the problems of chronic disease and the multiple needs of the aged for environmental and socio-economic support. "*The home, as the sociologist understands it, has broken down under the pressure of industrial development, and two wars have doubled this pressure. We might, therefore, say that the home has perished and the Home Help Service has begun.*"[1]

From World War II on, European governments have been involved in home help services in various ways: through legislation; through regulation and standardization of supervision, training and practice; through administration; and through direct financing or subsidy. This active participation has affected program growth; but more significantly, it has affected the status of home help services. Home help programs are considered essential. Workers who are employed in the programs are respected, and the conditions of their employment are protected. The field is generally regarded as one which is vocationally interesting and worth entering.

The results of long experience and practical government support can be seen first of all, and most impressively, in service volume. Swedish programs, which in 1943 employed 200 home helps, employed 4,000 in 1968: a ratio of one to approximately 2,000 population (a ratio of one to 1,500 population has been estimated as an adequate standard). In 1968, Denmark had a ratio of one home help to 760 population (6,200 workers); Norway, one tc 1,000; and Belgium, one to 2,700.[2] Programs in Great Britain employed 3,000 full-time and 32,000 part-time home helps in 1955.[3] By 1969, 69,000 home helps were employed, with the ratio of part-time to full-time workers remaining approximately the same.[4] However, part-time workers spend about two-thirds of their time in full-time employment.

The Netherlands—which counts both workers who have had full formal training and those who have not, as well as those who are employed full-time and those who work part-time—has approximately 35,712 home helps (about one-half in each of the above categories) serving a population of some 13 million.[5]

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* Adapted from *Homemaker/Home Health Aide Services in the U.S.*, published by the U.S. Department of Health, Education and Welfare, June 1973. This article was originally copyrighted by the National Council for Homemaker-Home Health Aide Services, Inc., 67 Irving Place, New York, N. Y.

In France, which had set a goal of 13,000 trained home helps by 1970, there were—about 5,000 in 1968 a ratio of approximately one to 10,000 population. Their current total estimated need is approximately 22,000 workers: one to 2,500 population. The disappointing growth in the French programs was sufficiently important to occasion debate in the French National Assembly.[6] Germany has approximately one trained worker to 5,800 population (about 3,000 workers).[7] Switzerland has one worker to 2,900 population. In most of the programs, a need is expressed for additional workers in order to achieve a better worker-to-population ratio.

European Attitude Toward Home Help

The general attitude toward services in the home prevalent throughout Western Europe is best expressed by the following remarks made by a leader in a remarkably innovative home help program in Sweden:

> In my country we now find it natural for various reasons—humanitarian, labor economic, and social economic—that nobody should stay in an institution if his social or medical problems can be solved in other ways.
>
> No old person should live in an old age home just because he has nowhere else to live, lacks furniture, or cannot clothe, clean or cook for himself. Lodgings can be provided, furniture can be bought, and home help can be found.
>
> Thus, the individual's independence, a very precious thing in human existence, is saved—and always at a lower price than institutional care.
>
> No one acutely or chronically ill should have to stay in a hospital if ambulant medical treatment or day hospital care could be used, maybe in combination with home help.[8]

Characteristics of Home Help Workers

Most European programs have well developed and clearly formulated ideas about the characteristics necessary for workers in home help services. The very wide variety of activities assigned to home helps, the length and content of most training programs, and the complexity of problems found in families considered candidates for home care indicate that home helps are expected to assume a good deal of responsibility.

> Making the best use of home help . . . depends, among other things, on the sort of people we can recruit, the quality of the training, how much we are prepared to pay, and the competence of the direction.[9]

In legislation, regulation, and prerequisites for entry into training, the personal and physical requirements which are essential are stressed. The following is the description which appears repeatedly in publications which describe the qualifications of the French "Travailleuse Familiale".

> The profession . . . is an exacting one which demands indispensable aptitudes and qualities . . .
>
> *Physical:* Good health, stability, normal vision and hearing, manual dexterity—quick response.
>
> *Intellectual:* Capacity for observation; sustained interest; systematic approach; a sense of organization; a good memory; discrimination, good sense, and judgment.
>
> *Personal:* An exceptional capacity for adaptation to people and to situations; flexibility and understanding; a social sense which is "open" to others; a sense of responsibility, emotional maturity; composure, self control; an affection for children; respect for household work.[10]

An indispensable requirement is the capacity to be discreet ("confidentiality").

In Denmark, the Ministry of Social Affairs states:

> Considering that . . . (it) is a very exacting task and that very much depends upon the manner in which it is carried out . . . her general ways and personal conduct are of very great importance . . . a thoughtless word or a rash act may very well harm the patient, the home, herself, and the institution for which she works.
>
> . . . (she) should be kind and helpful in all circumstances and should always keep in mind that the sick and the elderly are often in difficult situations.[11]

The Belgian statute states:

> The family aide has respect for the individual, for the liberty of conscience, and for the opinions of everyone . . .
>
> All that she learns, everything that is confided to her as she goes about her work must be a professional secret . . . even after her contract is terminated . . . She must respect and enrich the human dignity of her work.[12]

Emphasis upon the need for flexibility and understanding and for a temperament which has the special qualities of tolerance, kindness, stability, and respect for privacy, is universal. Requirements which stress with such specificity

"the sort of person" required, in terms of temperament, attitude and physical characteristics, are directly related to the concept of the importance and usefulness of the services.

Maturity and Age

Programs in the United States usually stress "maturity"; and there has been a tendency here to see this in chronological terms. Although maturity is implied in the European definitions, the "mature" home help is usually expected to achieve this quality through a combination of inherent characteristics, good training and supervision—it is not, in general, related to age. There is, in fact, considerable variation with respect to age requirements in the European programs, with a majority tending toward a younger age range. This is probably related to the prevalent attitude toward home help work as a vocation or profession—one which is selected in time for the necessary preparation to be completed early in life.

Some European programs set the age range in government regulation. Sweden accepts for training young women between the ages of 20 and 30; younger recruits are accepted for employment in certain aspects of in-home care in several of the programs. In Belgium the *senior helper* must be 25 years of age to qualify for admission to training, and the *homekeeper* must be 17 years of age (there is a difference in length of training and work assignments in the two age groups). Holland accepts recruits at 18 but makes a distinction in both training and work assignments between the "homemaker" (fully trained) and the "home help," who may be very young (15–16 years of age) and receives less training and very limited assignments. The minimum age for Denmark is 25. West Germany accepts recruits for training between 18 and 35 years of age. Older recruits are considered if they have had experience in the field (in institutions or hospitals), and are willing to complete a specially designed program. Switzerland accepts trainees in two age ranges: girls between 18 and 25 are required to complete a training program which is six months longer than mature recruits (accepted in the age range 25–40). France requires a minimum age of 20.

All the programs show in their publicity, and describe in general, a group of attractive, youthful workers, robust, and cheerfully performing a wide variety of household and personal care tasks. England emphasizes the chronologically mature home help. The English program—which had its major development during World War II, when younger workers were employed in war industries—drew primarily upon housewives. They were considered to be already experienced in homemaking, capable of providing services to children and, most importantly, the aging population and the disabled who, because of the war, no longer had family members available to them and for whom institutions were virtually non-existent. Women whose children were in school or employed and who were available for work on a part-time basis were a major resource. The pattern of recruiting mature experienced housewives able to work during those hours when their own household responsibilities are minimal has continued.

None of the European programs appears to support an idea occasionally advanced in the United States: that the work of the homemaker-home health aide is an excellent employment resource for the "older" worker, who cannot, for reasons of age, take on more rigorous employment. *Maturity is seen as a temperamental characteristic.* It is quite evident from the range of services provided and the general content of training that the field is one in which the entry requirement of good health appears to be amply justified.

The Quality of the Training

European programs in general place a great deal of emphasis on training. The longest training period is required in West Germany, which provides two years of training—one year in a residential school and one year in supervised institutional assignments (hospitals, homes for the aged, children's institutions) and in the field. Switzerland and Holland require 18 months of training (Holland currently plans to increase the requirement to two years); Finland requires approximately 20 months; Sweden, 15 months; and France, 7 months. Belgium has differing requirements in training for its two categories of workers: the "home helper" who is "polyvalent" (i.e., capable of serving in all situations) is required to complete 450 hours of theory, 15 days of institutional field experience and from 500 to 1,500 hours of supervised on-the-job training. The "senior helper" must complete 200 hours of theory, 150 hours in an institution for the aged (senior helpers are assigned exclusively to the aged), and a period of 150 to 300 hours in "practical training" with the aged and sick. Denmark offers a training program of two months following a period of six months of on-the-job experience. Supplementary "short term" courses are organized. England provides two to three weeks of training, plus short-term institutes and on-the-job training.

Residential versus Day School Training

There is considerable variation in the attitude toward residential versus day school training. Germany, Switzerland, France* and Sweden provide a major part of the training in residential schools.

> A good pedagogical environment is needed for the assimilation of the material. A residential school offers most favorable opportunities . . . (it) enables trainees to take an objective view of their own background . . . and . . . to know other ways of life. . . . More intense contact provides opportunity . . . to . . . the staff whose chances of observation are improved so that the trainees' capacities can be assessed more completely. The residential school must not be . . . only a boarding institution, but a 'forming center'. The building must provide space in which to stimulate learning while permanent group leaders must . . . guide the group throughout the entire course.[13]

Recruitment problems, which are beginning to develop, and the possibility that the mature worker may become a necessary and valuable recruitment source have raised some question about the commitment to boarding schools for training. Those who are committed appear to be reluctant to relinquish this pattern of training.

The writer discussed at some length the varying attitudes toward extended training programs with several of the leaders in the European home help field.[14] The rationale appears to be based upon several considerations. These, of course, differ according to the circumstances within the country involved, and the extent and scope of the services required of the home help within the different programs.

1. It is generally accepted in all programs that entry into the home, whether the services offered are extensive or limited, is in itself an activity which requires an unusual combination of qualities: sensitivity, judgment, and discrimination. There must also be a well developed capacity to adapt with tolerance to a wide variety of situations in which service recipients, who are usually in crisis, make heavy demands upon the home help who provides the services. Most program leaders stressed their conviction that these attributes are reliably produced by careful and extensive training.
2. There is considerable difference among countries in the basic education which has been available to trainees prior to entry into the field. "Many of the girls are post-war children. They have had little schooling, they have never known family life; if they are to help others they must be carefully trained."[15]
3. In several of the countries, a primary recruitment source has been rural girls. ". . . in Switzerland, the home helps are recruited nearly exclusively from country people. For instance, since the foundation . . . of the school of Zurich, 95 percent of the registrants have been the daughters of farmers . . . We try in our schools to show the problems of the city and the country and to point out which are common to both and which are different."[16] The Scandinavian countries are among those whose trainees are drawn primarily from rural areas.
4. Countries which stress younger trainees see the necessity for extensive training as essential vocational preparation.
5. The range of services offered in the various programs appear to affect the length of training. The definition of "personal care" as it has been established in the United States, is much extended in many European programs to include services of considerable complexity for which longer training is considered essential.

Program Content

Training content in the various programs is related to these factors. It is similar in almost all programs that offer organized training, differing only in emphasis, with one exception—those programs which to some extent intend to replace basic education (what we have recently begun to describe as "remediation") provide in their training programs for education in language (written and oral), mathematics, bookkeeping, money management, literature, music, athletics and gymnastics (apparently different activities). This general instruction is not extensive: at most it takes up 96 hours of a 2,070 hour curriculum in Germany, and the same number of hours in a slightly smaller total in Switzerland. It is not included in the Belgian, Danish or French courses—possibly because basic education is presumed to be adequate.

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* The training school in Paris is a day school; and the period of study extends beyond the seven month requirement to approximately one year (including field experience).

In France, for example, selection of recruits is preceded by entry examination:

> To make good use of [the course of study] the home help must be able to reflect, compare, investigate, judge. She must be able to take notes and to comprehend the thought of the person who gives the course.
>
> This is determined by an entry examination: in spelling, language formation, good sense; a psychological examination to determine aptitude; a trial period to determine qualities related to judgment, capacity to organize ideas and to take notes.[17]

The course of study in organized training programs is divided into training in theory, in practice, and in special fields of practice: i.e., field instruction and practice in specialized institutions:

A. Theory

Theoretical training begins in almost all programs with a discussion of the service.

I. The service
The profession
Range in emphasis: 7 hours to 90 hours
Professional and ethical practices
Behavior patterns and patterns of life (life styles)
Customs of the country
Moral problems*
Religion**
Social structure; its significance for beneficiaries (Belgium)

II. Professional† education

1. Housekeeping
Household management
Demonstration
Range in emphasis: 46 hours to 416 hours
Nutrition instruction and diet
Cooking, baking, sewing
Care of laundry
Housework
Horticulture/care of flowers (Switzerland)
Purchase of food and supplies
Budgeting
Gardening and care of cattle (Finland)

Almost all programs emphasize the teaching of nutrition and good diet as a responsibility of the home help.

2. Nursing
Principles of good health and maintenance of good health
Range in emphasis: 32 hours to 360 hours
Personal hygiene
Teaching the care of the sick
Care of the sick
Infant and maternity care
Pathology
Pedicure (Denmark)
First aid

III. Raising children‡ (Family life)
Cultivation of family life
Range in emphasis: 6 hours to 246 hours
Child development and training
Teaching child care and development (applied pedagogy)
Teaching occupations for children (vocational guidance)
Family problems

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* In the sense of tolerance, adaptability, restraint in making personal judgments, respect for family integrity; not in our literal interpretation of the word.

** Germany, Switzerland, Holland, Belgium. Holland: "Religious training and/or basic attitudes to life. Orientation with respect to currents in religious thought."

† The word "professional" which is used consistently is usually meant in the sense of following a chosen occupation. In France, however, it is used in the accepted sense: the French program emphasizes that it considers the Travailleuse Familiale a professional worker.

‡ This is not so specifically related to child care as it is to family life. It includes care of the aging and "training for aging". (France)

Problems of the aging
Care of the aging
Handiwork and hobbies (Finland)

Here again, teaching ("pedagogy" is one of the subjects taught in almost all programs) is the responsibility of the home help.

Range in emphasis: 13 hours to 170 hours

IV. Knowledge of Social Work*
Social science including family affairs
Social science; manners and customs; family life; welfare and professional practices; law, social legislation, citizenship, cooperation between home care and other social services.

B. Procedures (Practice)

Range in emphasis: 80 hours to 510 hours

1. Care of the sick and aging
given in hospitals, nursing homes, outpatient departments, homes for the aging and chronically ill; in the home.

50 hours to 274 hours

2. Prenatal and infant care
given in foundling homes, maternity homes, in family placement.

85 hours to 768 hours

3. "Raising Children"
given in children's homes, day care centers; kindergartens; in family placement.

C. Professional Procedures under direction and supervision of school (in-service training)—12 months to two weeks.

Most of the schools are government financed, and tuition and maintenance are provided the trainee, either by the government or by a combined funding (private program or local authority plus government subsidy).

Various countries emphasize different aspects of training, according to program need. There is relatively greater emphasis (in hours related to the course total) on household services in Sweden and France; Germany and Finland devote relatively larger sections of training to care of the sick; Switzerland and France emphasize larger blocks of time in institutional practice; and Germany and Holland require one full year of extended (supervised practice) training under the direction of the school.

The course of study in Great Britain, which relies primarily on on-the-job training, covers much of the same material as that which has been outlined above: household management, nutrition and special diets, and personal care (lifting, turning the patient in bed, hygiene, and first aid).

Training is usually provided by qualified professional instructors drawn from the specialized fields. Authorization to teach certain courses may be given to other persons who are particularly qualified in family problems or specialists in group dynamics.

There is apparently a strong coordinated system which integrates the central training facility, the institutional field practice, and supervised training in family placement, particularly in those countries which have extended and well developed training programs.

The Services: Scope, Duration, Limitations

In all of the European programs heavy emphasis is placed upon those services which protect and increase the quality of family life and which "instruct" families in methods intended to achieve these objectives. This by no means implies that the assignment of the home help is confined to teaching.

Housework

Home helps in all European programs are expected to perform those household tasks which are a part of the normal homemaker's routine. *In England:*

* "Social Work" in this context is related to social insurance and the rights of the family and the individual in the social system—very important in European countries, as well as to social work concepts as we know them.

> We expect home helps to do *whatever is needed.* They are sent in to help. This means unlimited service except for those tasks which cannot be safely undertaken. It is far better to give unlimited service . . . at home (including medical care and supportive services), than to put them in hospital or nursing homes.[18]

The care of incontinent bedfast patients is considered a normal part of the home help's assignment in England. The English program supplies a "Blitzclean" service for heavy janitorial work; meals-on-wheels programs have been developed; and home help services are coordinated with the services of the district nurse, the physician, *the geriatrics worker*, and the mental health officer.

In France:

> All of the tasks habitually undertaken by the homemaker: housework, cooking, the care of children, laundry ironing and mending (laundry of drapes, washing of large windows are forbidden; laundry of household linens is limited to two hours a day).[19]

In Sweden:

> The trained home help . . . is expected to work in homes of the most varying standards and economic resources and to take over all the regular household duties such as cooking, shopping, cleaning, taking care of the children . . . helping them with their homework and also, at times, doing some nursing. Although a home help is expected to do the housewife's ordinary work, we should expect a competence far beyond that of the *ordinary housewife* . . . (emphasis added).
>
> The permanent home help to the chronically ill or handicapped . . . or old people who are more or less ill who, besides the ordinary housework must be prepared to help with personal hygiene and do some nursing . . .
>
> The home help to old people living in sparsely populated regions where modern equipment is rare—people who can take care of themselves, but need help to draw water, fetch wood, and shovel away snow.[20]

Food

Food preparation and nutrition are heavily emphasized in all of the programs. Home helps are expected to prepare substantial meals, to bake, to preserve and can (particularly in rural areas), and to be very knowledgeable about good principles of nutrition, particularly in child care and in the care of the sick. Convenience foods, supermarkets and specialized household equipment which allow for food storage are only beginning to appear in many European countries; and the attitude toward mealtime as an important part of family life is still that of a more leisurely family-centered culture. The two-hour lunch period in which workers go home to lunch is still fairly prevalent; home helps are expected to continue existing family patterns and, where it appears to be deficient, to improve general family nutrition. English home helps may leave and return to a given home several times during the day, to provide for tea times as well as basic meals.

Care of Clothing

Mending, alteration of clothing, and the making of clothing—particularly in child care—are also provided in most programs. Here, too, the fact that the use of ready-to-wear clothing is not yet a basic way of life has its effect.

Personal Care

The word "nursing" appears frequently in training outlines and in brochures which describe European home help programs. Yet in interviews with the writer, program directors, in response to the direct question "Do you provide nursing care?" invariably responded negatively, saying that nursing services are provided by the district nurse. Home nursing—which might normally be undertaken by family members—is naturally considered appropriate for home help, but the services do seem to go beyond these. Many of the services related to prenatal care, postnatal care and care of the newborn—which we usually assign to the public health nurse—are in some programs (particularly those with extended training programs) provided by the home help.

In adult care, there is some variation between programs. English home helps turn the patient in bed and lift and move patients from bed to chair, but do not give bed baths. The longer training programs are geared to the provision of most services short of giving injections or doing very specific nursing procedures.

Most of the services which we consider *personal care* are provided; medication is offered in some programs. The training outlines indicate that "nursing care" of the aged accounts for from 33 percent to 40 percent of training time

in four countries (Germany, Finland, Switzerland, Sweden), all of them providing extensive training. What is taught might come fairly close to preparation for the services given (with some restrictions) by a "licensed practical nurse," in the United States. "Pre- and postnatal care, baby-nursing, nursing of children" uses from 25 percent to 62 percent of training time in five countries (France, Switzerland, Finland, Sweden, Germany). What is taught appears to equip the home helps in these countries to provide a combination of the services that the United States public health nurses provide and/or teach family members to provide. England, Denmark, and Holland appear to provide services that more closely parallel the U.S. definition of "personal care", although English home helps do "give some medication." In all of the countries, however, provision of these services is firmly tied to supervision by the physician and the district nurse. The Scandinavian countries, primarily, add to the training and the services offered those which are more closely related to physiotherapy: positioning, body movement, prenatal exercises.

Social Services

Regardless of auspices and of the factor of illness as a presenting need, all programs are firmly committed to the overriding "social" and psychological considerations in both training and service. Supervision is most frequently provided by social workers. More important, there is a constant reiteration of the need for considerable knowledge of and sensitivity to psycho-social aspects in all situations.

The "normal" needs for assistance, which involve recurring practical problems—assistance when there is illess, when the mother of a family is absent, or when housing or other basic necessities are deficient—are taken for granted as an ongoing responsibility of the home help services. In addition, the family must have recourse to help which motivates, stimulates, reassures, and assists in those choices which make maximum use of social institutions, at the same time preserving that which supports internal autonomy.

This "mission," or assignment to the home help of the responsibility to support the family "vis-a-vis an external world which is largely indifferent, a society which is neutral,"[21] organizations and institutions which are complex and specialized, and choices which involve the clarification of the family's value system as against a confusing variety of choices and values, is a common characteristic in training content and the description of services.

"Deontology" and "Puericulture"—an important part of extended training programs—describe ethical training which goes beyond professional ethics to attention to family life that is in-depth and specific. It is strongly family-centered and is most characteristic of continental programs, particularly those which place their major emphasis on child care—on the "family of the future." It also explains the distinction made between training for the care of the aged, the disabled, and the chronically ill which—in spite of the heavy component of personal care needs—is a shorter course, and in some countries make use of a different kind of trainee (although the general trend toward the "polyvalent" home help has become evident). This approach does not exclude concepts which in the United States are included in psycho-social orientation of homemaker-home health aides and in the social services which are offered in our programs of quality.

There is great emphasis on family and individual autonomy, and on the enabling aspects of healthy relationships. Psychological concepts are very important in some training programs; and whether or not they are specifically taught, the very delicate position of the home help—intimately involved in the lives and problems of families—is thoroughly understood, and the value of objectivity combined with warmth is certainly recognized.

A third aspect of social services, and one which is important in European programs, is related to the multiple "rights" of individuals and families to various benefits, under the social insurance programs. Health insurance benefits, disability benefits, family allowance grants, supplementary grants to families with single earners, unemployment insurance, and pension plans play a very important part in the economic life of the European family, as do the many forms of private agency and religious group assistance programs. The home help, under professional supervision, is expected to be familiar with these and to assist families who are unaware of what might be available to them to take advantage of them.

In terms of breadth and scope of services, the program most admired in Europe—particularly in its services to the aged and chronically ill—is the program developed in Sweden. Virtually every need essential to safe and comfortable home care has been made mobile and is brought into the home. Meals-on-wheels, physical and occupational therapy, mobile coiffeur and shampooing service, chiropody, transportation services, organized recreation and friendly visitors, and special restaurant services are important complements to the home help service and may even, in certain situations, replace it.[22] Day care, and weekend and holiday homes are also a part of the Swedish program.

Duration and Pattern of Service

Programs which emphasize child care, and in which care for the aged, disabled or chronically ill has either been a later development or is just beginning to develop tend to limit the duration of service. These distinguish between situations of crisis when one or both parents are temporarily ill and/or out of the home, and those situations where problems are of long duration and require a restructuring of family life with the assistance of the supervised home help. Germany limits the service from four to six weeks, with extension in very rare exceptions; Holland does not give unlimited (in duration) home help, but will provide extended care on the basis of the family situation. Belgium limits assistance in child care from two to approximately three months; Denmark provides child care assistance for 14 days with extensions *as needed*; France, which emphasizes care in situations where large families or unusual stress may be overwhelming to the mother, limits service to the extent that personnel is limited, but it does provide long-term service.

Services to the aged are viewed somewhat differently. England, which provides care to all age groups, bases the length of care upon need. There is no limit in duration, the objective being to maintain people at home as long as possible. Countries which provide services to the aging population tend to take this position:

> It is the business of the home help to assist *invalidity* and *old age pensioners* who are in need of more permanent help. Home help is designed to enable the pensioner to live in his own home for as long as possible.[23]

Since the old age pension is a right and is not dependent on indigence, virtually any aged person may receive home help when they need it. This is also the case in Sweden, Finland, and Holland, which do not limit duration in their services to the aged.

The pattern of service (assignment time) in all countries is extremely flexible. Countries emphasizing child care tend to full-time (40 hours or longer per week) assignments, since the presenting situation is usually the illness or absence from the home of the mother, employment of the father, and the presence in the home of children who need care and supervision. In England the child care service volume is small in relation to adult service. Home helpers are polyvalent in England; they shift flexibly from child care assignments to those involving the aged and infirm. In child care, however, assignments tend to meet the need.

Although there is no restriction on the hours of assignments to the aged and disabled in England, a part-time service tends to be the rule. Because of the saturation of staff, it is possible for this part-time arrangement to be geared to the individual pattern of living:

> We are apt, with older people, to send the home help in two or three times a day. She will arrive at eight in the morning to help with washing and bathing, change bed linen and get breakfast. She (or another home help in the district) will come in to give the noon meal, or it may be delivered. She may come in to fix a cup of afternoon tea and again in the evening to get the evening meal or get the person to bed.[24]

This pattern of part-time or intermittent service for older people, service two to three times a week or for a few hours daily, is prevalent. All programs which serve this age group indicate that this pattern has been adopted because it appears to work well; full-time service may be provided, although programs with limited or minimal services to the aged restrict the length of full-time assignments.

Obstacles to full-time services differ in various countries; these are not invariably financial, although the funding of services lacking a reliable financial base may exert pressure in a few programs. Recently, with full employment related to rapid post-war industrialization, recruitment has begun to be a problem. In England the supply of mature women interested in part-time work appears to have diminished markedly. Germany is considering an alternate training program for more mature women beyond the required age range because fewer young women have been available; this is equally true in Holland and Belgium. Young women in France and in the Scandinavian countries view the status of the work as equal to or superior to clerical employment; and Sweden supplements the services with a substantial corps of friendly visitors.

Recipients of Service

Although all programs indicate that they serve in all age groups, the early emphasis on family life and child care has remained the basic home help program in some countries (France, Germany, Holland, and Switzerland). These tend to provide services to older persons when they are members of the family group.*

* The growth of an aging population in European countries has begun to affect home help services. The International Congress sponsored a seminar in 1971 which focused exclusively on the needs of the aging and extension of services in home help programs to the adult group.

New "special problem" categories are being included in training and service programs, i.e., alcoholism, mental illness, and services to immigrants. Alcoholism and mental illness (the latter, particularly in young mothers) in Germany; all three in France, and services to massively handicapped individuals who are living alone in Belgium are later developments. There is less tendency to categorize groups in countries which have basic government funding, the service being offered generally to anyone in need.

In services to the aged, England historically made the first major approach to the problem of its aging population during World War II. By 1960, services to families with children (which had been established since 1895) were given in 74,846 families; to the aged and disabled in 214,654 families.[25] In 1969 services were provided to about 500,000 cases, of which three-fifths to four-fifths were in the group described as aged and infirm.

All of the Scandinavian countries provide services to both groups. The development of services to aged persons in their own homes was stimulated by something more than economic considerations:

> The description of the British system published in 1948 in a Swedish journal stimulated lively discussion among the officials, the social workers and the professors of home help training. . . . We were not even certain that they (the aged) really needed help in their own homes at a time when . . . homes for the aged were comfortable, modern apartments were being built for pensioners and when we believed that the majority of older people wanted to care for themselves . . . or to be cared for by their families or their friends. In fact, it was doubtful that we could recruit personnel for this kind of work because of a lack of employment.
>
> Now, fifteen years after our first tentative approaches, home help for aging and invalids is so well distributed in our country, with its population of 7.7 million, that in 1965 we were able to provide (home help) service to approximately 144,443 aged and incapacitated persons (a total of 17,175,680 hours of service). Close to 8 percent of our aged population received the service. In each municipality . . . aged and incapacitated persons were helped either by specialized home helps reserved for the aged or by home helps with diplomas working full time.[26]
>
> The creation of the first home help service for aged persons is about a dozen years old. The experience has been such a positive one that no one can pretend any longer that it is a temporary activity, a palliative dictated by crowded hospices, boarding homes or hospitals, since the development witnesses to the responsibility and to the growing respect which society owes to the individual and to his liberty.[27]

Financial Eligibility

Although there are provisions for financial participation of the family in almost all programs, the ability of the family to pay for services is not an important element in any program. In programs built into the social insurance system, anyone who needs the service may receive it, the costs being absorbed by state and local funding (England and the Scandinavian programs). In countries that provide government subsidy or rely upon combinations of government subsidy, private funds and selected insurance benefits, services are funded through these combinations (France, Germany, Belgium, Holland, Switzerland). In these latter programs, funding tends to affect overall program growth rather than individual eligibility.

Funding, Auspices, and Program Direction

Wages, personnel practices, and the conditions of employment are all closely linked when the desirability of any occupation is being considered. Wages in France and in the Netherlands are approximately the same for home helps as for clerical workers. England pays a "fair wage."

> Salaries . . . are generally lower than a fair remuneration in view of the services the home help renders, the requirements exacted, and the social character of the profession.[28]

Countries which provide, through legislation and funding, for the general availability of the services usually regulate wages, hours, and conditions of employment (sick leave, vacation, travel) as a part of the general program. Hours of work and protective regulations are usually, in any case, kept fairly standard since several of the countries have established internal associations of home help services, making for a degree of standardization. Workers in countries having extensive social insurance programs (and this really includes most countries of Western Europe) are usually covered by a variety of insurance benefits; these are not so universally available to homemaker-home health aides in the United States.

At the 1969 International Congress, the necessity for further progress in the establishment of standards of payment, hours of work, protection against illness, accident, old age and vacation time beyond what is provided by "laws in force" was stressed.

Auspices

In England, Denmark, Sweden, Norway and Finland there is legislation which establishes the requirement that home help services must be established in local communities. Central responsibility for the English program is placed in the Ministry of Health and in the local health authority. Funds are made available from the National Health Service Budget to each local health authority for the cost of the home help service. This pattern is followed by the Scandinavian programs, except that they are placed in the Ministries of Social Affairs (in Norway, the Ministry of Family and Consumer Affairs). Funding is therefore a public responsibility in all of these countries, with subventions either coming in full from the National Governments or based upon a national-local formula for cost sharing.

France, Belgium, the Netherlands and West Germany have somewhat different patterns. In France, responsibility for regulation of training and services is placed in the Ministry of Health, and the services are funded through a combination of government subventions and participatory financing by the local "Caisses Familiales" (family associations which have the status of unions and which carry a variety of responsibilities in public services and in the social insurance programs). Religious and voluntary home help programs, of which there are about a dozen, participate in the program and are governed by legislative regulations concerning training, services and conditions of employment. All are grouped in a national committee or federation of Home Health Associations.

The programs in the Netherlands are administered by private organizations, most of them religious. Government subventions are made through the Ministry of Cultural Affairs, Recreation and Social Welfare on a formula which in 1971 consisted of 90 percent of costs for supervision, 70 percent of costs for salaries of *trained* home helps, 50 percent of the salaries of *untrained* homehelps, and 85 percent of the salaries of "workers with the aged."* An additional subvention is provided for administration, with a supplement for programs having "competent" direction. Local authorities provide additional program subsidies. Subsidy preference is given to programs designated by the Ministry as "A" organizations. They are those which have a range of supervisory skills represented (nurse, social worker, professional administration) and trained home helps. Stimulation of quality through an increased ratio of subsidy appears to be an interesting and potentially successful way to improve services.

Belgium regulates training length and content by government decree in the Ministry of Health and Family Affairs, designates the minimum requirements for programs which may receive subventions (professional supervision, minimum size of staff, services which must be provided, wages and personnel practices), and provides subventions which consist of an established amount per hour of service for administration, 75 percent of the costs of social security payments for workers, and a portion of the salaries of home helps (to be fixed at 75 percent of the hourly cost after fees have been deducted). Services are provided through private organizations, many of them religious.

West Germany does not have available national funding for services. Local governments, however, provide funds for home help services, and insurance benefits provide payment for services. Services are financed by a combination of these and family payments (of which only 1 percent are full fee). In Frankfurt, about 95 percent of the population is insured under the health insurance program which will pay for home help services if they are given by trained home helps. Services are provided by private agencies grouped together in an association.

In Switzerland, the Ministry of Health and Welfare regulates training, and the various cantons differ in their methods of funding services. Some are voluntary, some completely public. Public subsidies are provided when the services are administered by private agencies.

Program Direction

Program direction and supervision are almost always provided by professionals. Supervisors, "organizers", or "responsibles" are drawn primarily from the fields of social work and nursing or have had experience in related helping professions. There is a two-year training program for organizers in England and a similar program in Holland. France has a series of conferences and institutes, many of them focused on new or problem areas of the services. The 1969 International Congress recognized the need for "competent direction" particularly in those areas which do not assign this responsibility to professionals.

* It is interesting to note that these subventions were greatly increased in 1971. In 1969 they were: 40 percent for supervision; 35 percent for salaries of trained home helps; 25 percent of salaries of untrained home helps; and 35 percent of salaries of workers with the aged (supplementary material from Dr. Scholten March, 1971).

Conclusion

These programs which express so strongly an anti-institutional bias, appear to be only superficially based in economic considerations, although such considerations cannot be ignored as a part of the anti-institutional bias. They carry, above all, an overtone of ideological and philosophical intensity. Systematic social security has been a fact in most European countries since the 19th century: it has been an institutionalized approach to what Europeans consider the rights of individuals to at least a minimal personal security which is guaranteed by the culture and by the organized social structure. The anti-institutional stance evidenced by the serious approach to an investment in-home care is another expression.

Home care itself is a part of the social institutions of European countries because of this essential belief in the right of the individual to protection of his "personal" self in his "own family" environment in times of stress, crisis or failing vigor.

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PRESENT STATUS OF HOMEMAKER-HOME HELP SERVICES IN DEVELOPED COUNTRIES

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What information do we have on the provision of services in more developed countries? For the United States the two principal sources are the reports which Brahna Trager has done for the Special Senate Committee on Aging and information available from the National Council for Homemaker-Home Health Aides, Inc. Certain studies have also been done at Brandeis University, under the direction of Robert Morris. For other countries the principal source is the International Council on Homehelp Services, founded in 1959, with headquarters in Utrecht, the Netherlands. There are some 19 countries considered to have significant programs, 16 of whom are members of the International Council.* Reports of members, plus additional information made available at meetings held in 1971, 1972 and 1973 provide a starting point for viewing the present development of services.

In the United States the thrust of the National Council has been to develop in every region of the country quality agencies which can be certified as meeting specified standards. At the same time the Council works with other organizations to influence Federal legislation and regulations, as well as to promote more adequate funding mechanisms. Their reports indicate a growth in the number of administrative units for homemaker-home health aide services from 150 in 1958 to some 3,000 in 1972. Private, non-profit agencies, which represented over three-fourths of the units in the earlier year, were only two-fifths in the latter year, with public agencies administering a half, and proprietary agencies now representing almost one-tenth of the total. The Council also reports that here has been an increase in the number of aides, from 3,900 in 1963 to approximately 30,000 in 1972.

Although the growth has been desirable, the position of the Council has been that the number of aides is still far too low. For example, if one aide for each 1,000 persons in the general population and one for each 100 persons aged 65 and over is adopted as a standard, then 300,000 aides, or 10 times the 1972 number, would be needed. If the British standard of 150 per 100,000 population by 1983 is used, then an additional increase in numbers, to some 450,000 would be called for.

The question of standards is a thorny one, which requires further international examination on a regional or global basis. (A U.N. approach to standards will be discussed below.) Meanwhile, Brahna Trager's work, augmented by meetings and hearings sponsored by the Senate Special Committee on Aging, points to a situation of contradiction and paradox in efforts to expand American services. Despite lip service to the need, Medicare and Medicaid programs have actually presented roadblocks to present or potential providers. Medicare/Medicaid only reimburse certain limited categories of need. Even if eligibility is established, it is only for a limited time, and there is a collection gap before payments are received. The fact that older persons need chronic rather than acute care, not necessarily medically based, has not been faced in the U. S.

There is some evidence that the number of home health agencies in the United States has actually declined within the past year. Present services are found to be more costly, less helpful and less accessible to potential consumers. There is fear that the field will go the way of private nursing homes, with a burgeoning of proprietary services available largely to those who can afford to pay.

What is the situation in other countries? In those countries which have visible services there is great diversity, which begins with the name by which the services are called. *Home help, house-keeper, home samaritan, domestic services employee, aide familiale, Hauspflege* are some of the names used, not always in the same way. The British term *home help* is the one most frequently found.

* Iceland and Ireland are reportedly considering membership. There are also some services in South Africa. The latest report from the Council (May 1974) announces the admission of a second Australian organization, the Perth Emergency Housekeeper Service, as a provisional member. The service is described as having 60 part-time home-helps and 24 live-in home-helps.

There is a wide diversity of approaches to the 8 major parameters of service:

1. **Age and sex of helper:** typically a "warm, healthy" middle-aged woman; may be a young woman, married or unmarried; occasionally male.
2. **Conditions of employment:** volunteer; paid; part-time, full time; self-employed, employed by private agency, employed by proprietary agency, employed by public agency.
3. **Training:** none; brief orientation to job; in-service training; professional training courses of 1 to 2 years.
4. **Supervision:** none; informal; administrative only; "as-and-if-needed"; professional supervision and evaluation; peer groups; meetings with consultants.
5. **Intensity of service:** one hour or less weekly; two half-days weekly; daily; 24-hour; weekend; emergency.
6. **Duration of Service:** short-, middle-, or long-term; time-limited or indefinite; pre- or post-hospital; concurrent with medically-directed program or unrelated.
7. **Auspices and financing:** by recipients or relatives; by private non-profit agencies, with fee scale; by proprietary firms, profit making; by hospitals; by public welfare; by private insurance; by national health insurance; by research and demonstration programs.
8. **Populations served:** families with children; disabled of all ages; physically and mentally handicapped; elderly; indigent only.

It seems that each country, like a family, chooses the kind of home-delivered service felt appropriate to its own culture and stage of development, as well as the method of financing it finds most acceptable.

There is also wide variation in the levels of care offered, as well as the specific tasks involved. The three levels or components of care are: housekeeping—errands—chores; personal care; education/counseling. A quality program would include all three. Not every level is offered in every country, and in some a basic home economics education program may precede direct services. Duties also vary with climate, type of housing and related facilities; availability of transportation: customs and mores. There are more duties in cold climates, such as laying and lighting fires in England; and in rural areas, such as cattle-tending in Finland.* Overall, there is a tendency to replicate the pattern of duties expected of a mother or daughter in a given cultural situation.

There are thus two divergent approaches to the provision of services. The first utilizes a marginal and part-time labor force recruited mainly from women not otherwise in paid employment, having personal characteristics similar to those of the recipients. This is the dominant approach, and the way in which many new services get started. By contrast is the pattern emerging in the most developed programs in the Scandinavian countries and in western Europe, which utilize a trained labor force in organized programs, with a substantial base of public funding, aimed at providing a basic community service to meet defined categories of need for a specified length of time.

Services to the elderly usually are given a low priority under the first kind of approach. They have a defined position in the more organized institutional approach. However, it is difficult to match the performance of the British service which, in a time of reorganization and transition, has expanded total services, 85% to 90% of which still go to the older persons.

Quantitative Factors

Reports by members of the International Council of Homehelp Services (*See Table 1*) provide a notion of the numbers of organizations and of helpers involved.

The largest number of organizations listed is 9 for France, followed by 7 for the Netherlands, 6 for Belgium and 5 for West Germany. These figures indicate only the number of member organizations. For example, in the case of the United States, only one organization is listed, referring to the National Council.

For the 16 countries reporting there is a total of 281,409 workers, or fewer than 300,000, of whom over 200,000

* A report given at the 1973 London conference described the Finnish helpers as very competent in most of their work, but a bit weak in cattle tending.

Table 1. The number of home help organizations and the number and percent of full-time and part-time workers reported in selected countries, 1973.

		Number of workers			*Percent of workers*		
Name of country	*No. of organizations*	*Total*	*Full-time*	*Part-time*	*Total*	*Full-time*	*Part-time*
Australia	1	30	—	30	100%	—	100%
Austria	2	355	250	105	100	70	30
Belgium	6	4,018	2,864	1,154	100	71	29
Canada	1	5,000	1,000	4,000	100	20	80
Finland	1	4,556	2,327	2,229	100	51	49
France	9	7,144	5,197	1,947	100	73	27
Great Britain	4	67,439	3,183	64,256	100	5	95
Israel	1	273	—	273	100	—	100
Italy	1	50	5	45	100	10	90
Japan	1	9,220	7,155	2,065	100	78	22
Netherlands	7	52,130	13,280	8,850	100	25	75
Norway	1	22,231	2,269	19,962	100	10	90
Sweden	1	65,700	3,650	62,050	100	6	94
Switzerland	3	2,060	1,155	905	100	56	44
United States	1	30,000	n.a.	n.a.	100	n.a.	n.a.
West Germany	5	11,203	2,814	8,389	100	25	75
Total	45	281,409	45,149	202,260	100	18	82

Source: International Council of Homehelp Services

Table 2. The number of home help reported in selected countries for the years 1970, 1972 and 1973, arranged according to rank order for the two latter years.

	Year		
Country	*1970*	*1972*	*1973*
1. Great Britain	59,252	66,943	67,439
2. Sweden	19,200	63,238	65,700
3. United States	4,069	20,000	30,000
4. Netherlands	12,256	17,597	52,130
5. Norway	1,600	15,847	22,231
6. W. Germany	11,500	11,170	11,203
7. France	4,861	6,695	7,144
8. Belgium	2,360	4,583	4,018
9. Canada	—	3,200	5,000
10. Switzerland	1,620	2,044	2,060
11. Finland	1,593	1,686	4,556
12. Israel	117	273	273
13. Austria	240	250	355
14. Italy	50	50	50
15. Australia	—	20	30
16. Japan*	n.a.	n.a.	9,220
Total	118,718	213,596	281,409

Source: International Council on Homehelp Services
* Japanese figures supplied by Mr. Mikio Mori

are part-time. All of the workers in some countries are part-time, e.g. in Australia and Israel.* In Finland and in Switzerland there is a fairly even split between full-time and part-time. There are only four countries (Austria, Belgium, France, Japan) which list the majority of workers as full-time. By contrast are seven for which the majority is part-time (W. Germany, Canada, Great Britain, Italy, Norway, Netherlands, Sweden). The U.S. breakdown is not given. However, the field is characterized by predominantly part-time employment in all but a few countries.

Table 3. The ratio of home help per 100,000 population in selected countries, as reported in May 1973

Name of country	*Total population (in millions)*	*Number of home help*	*Ratio/100,000 population*
Sweden	7,968	65,700	825
Norway	3,851	22,231	577
Netherlands	12,878	52,130	405
Great Britain	48,988	67,439	138
Finland	4,688	4,556	97
Belgium	9,581	4,018	42
Switzerland	6,150	2,060	33
Canada	21,377	5,000	23
West Germany	58,653	11,203	19
United States	203,166	30,000	15
France	49,756	7,144	14
Israel	2,879	273	9
Austria	7,373	355	5
Australia	12,296	30	0.2
Italy	53,708	50	0.1
Japan*	107,372	9,220	9

Source: International Council on Homehelp Services
* Japanese figures supplied by Mr. Mikio Mori

There appears to have been a significant increase in the known total of home helpers between the years 1970 and 1972, about 80% for the 15 countries reporting. (*See Table 2.*) Except for Italy, the number is larger for every country. Between 1972 and 1973 there was a further increase, but less marked, in the neighborhood of 27% for a one-year period. Every country made some gains, with the exception of Belgium, which reported fewer workers in 1973, and Israel and Italy, both of whom reported the same numbers as in 1972. More information would make it possible to pinpoint the most effective ways of increasing the supply in a short period. For example, what explains the spectacular gains in the Netherlands, and the very dramatic gains in Norway and in Finland?

The ranking of countries according to the numbers of home help employed is also of inteerst. The first five countries are identical for the years 1972 and 1973: Great Britain, Sweden, United States, Netherlands and Norway. For 1970, however, Netherlands was listed as third, West Germany as fourth, and France as fifth.

Measured in this way, the United States and Norway appear to have made notable gains by making it into the ranks of the top five.

At best, this kind of numbers game is only a crude measure of progress. A preferred yardstick in this field has come to be the number of home help per 100,000 population.

Using this ratio as a rough measure of provision, the ranking of 15 countries for the year 1973 shows the United States as tenth. Australia and Italy appear as the lowest for both years. If Japan were added, its services would be about on a level with Israel, tied for twelfth position. (*Table 3.*)

The four leading countries (Sweden, Norway, Netherlands, Great Britain show significantly higher ratios than the others listed. In fact, the countries for whom some figures are available would appear to fall into four distinct groups:

1. *Group A*—Sweden, Norway, Netherlands, Great Britain
2. *Group B*—Finland, Belgium, Switzerland, Canada, W. Germany
3. *Group C*—United States, France, Israel, Japan, Austria
4. *Group D*—Australia, Italy

The use of the ratio suggests that the *minimum level* of known services is 1/100,000 or fewer (*Group D*); the *indicative level* is between 2 and 100 (*Groups B and C*). The four leaders (*Group A*), with ratios better than 100 are the closest to achieving a *maximum standard* of service, in quantitative terms.

* In the case of Israel, as in other countries, this represents a policy decision, to make the work more attractive to women with their own households to manage.

Using the ratio as a measure of home help adequacy is clearly better than raw numbers unrelated to population figures, but could well be further refined to take into account such factors as the age distribution of the population, rural—urban areas, and the like. It would also be useful to relate the numbers to an income measure, such as per capita income. It can not be assumed either on theoretical or practical grounds that every country, regardless of geographic location or stage of economic and social development, should select as a target the ratios attained in quite different countries.

What should the "ideal" ratio be for a developed country? A British study by L. G. Moseley suggests that for Britain a ratio of between 300 to 400 home helps per 100,000 households would be an appropriate goal for national planning. This is double (or more) the ratio of 150/100,00 which local authorities were asked to plan by 1983, and far exceeds the ratio presently attained by any but the three leading countries.

Qualitative factors involved in the setting of standards have been virtually unstudied. Although Moseley argues that there is by and large consumer satisfaction with present British services, other evidence suggests that there may be serious deficiencies in the type of service given, intensity and frequency of services to old persons currently served, as well as a failure to serve persons and families not presently included.

The U.N. Approach to Standards

U.N. concern with standards for social services can be traced from the Conference of Ministers responsible for social welfare held in New York in September, 1968. Considerable work on the question of specifying standards has since been done in the ECAFE region.* The concept of three levels of standards: *minimum, indicative, maximum,* although it has so far been applied largely to services for children, appears to have great potential utility for analyzing services for the elderly:

A **minimum** standard is a mandatory requirement established by law, ordinance or cabinet order; it may or may not be enforced. Prevailing standards, e.g. of private agencies, may exceed minimum requirements.

A **maximum** standard is a target or goal used in long-range social welfare planning by governments or a council of social agencies.

An **indicative** standard is a guideline, which may be established by regional or international discussions, but is not enforceable unless subsequently adopted in the form of international conventions and ratified by Governments. The U.N. report on the elderly includes this kind of guideline, both for national and international action.

The three levels of home care mentioned below are conceptualized as *supplementary* to the care which in every country is given by the informal sector: family, neighbors, random volunteers. A better term might be the levels of organized home care:

Level 1. **Domestic (Environmental) Duties.** This level includes housekeeping (meals, laundry, chores) shopping errands and transport escort.

Level 2. **Personal Care.** This level includes home nursing, as well as the kinds of help with bathing, dressing, etc. which might be given by a family member if available. In more developed countries a line is drawn between these and procedures for which nursing training and supervision is required, such as injections.

Level 3. **Education/Counseling.** This level includes basic training in nutrition, child care, home management. In more developed countries trained persons are seen as performing a counseling, or family therapy function.

Whatever the level of services offered, the care-provider becomes involved in a personal relationship with the recipient, which is significant for both.

Service on all three levels may be considered a maximum standard, whereas service on two levels would be an indicative standard. In western countries we tend to think of such services as moving in a natural progression from the first through the second to the third level of care.

* See for example, International Conference on Social Welfare, Regional Office for Asia and Western Pacific, *Report* or *Expert Group Meeting on Standards and Legislation for Social Welfare Services* held at Seoul, Korea, August 29 to September 1, 1973.

The existence of any home-delivered services on only one of the three defined levels may be viewed as a weak social indicator of commitment to the value of community living for the elderly. The existence of all three levels of service is considered a stronger indicator. When it can be calculated, the ratio of the known number of helpers per 100,000 population will be used as a possible measure of the extent to which present services meet minimum, indicative and maximum standards of care.

Should *Group A* countries (*see p. 19*) be viewed as at a maximum or at an indicative standard? Based on their own needs assessments, each of the leading countries is meeting only a portion of the known need, even though all three levels of organized care are offered. There is, therefore, an apparent worldwide deficit in known services, as well as wide variations in the amount of effort currently expended.

As we look ahead to the year 2,000 and to a worldwide policy on aging, how should we set our sights? A minimal-standards policy is one which would respond to the needs of older persons by providing a mix of institution-based services, with a larger allocation of resources to the former. An indicative-standards policy is one which would recognize the increase in the numbers and proportion of the aged in all countries by providing a level of services designed to meet the defined needs of this population at risk. A maximum-standards policy is one which would recognize not only the increase in numbers but also the deficits in existing services, and would therefore plan to increase both institution-based and community-based services at a faster rate than the rate of population increase, with a greater investment in community-based services.

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HOME HELP SERVICES FOR THE ELDERLY: THE BRITISH EXPERIENCE

by

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The crucial issue for home help services is whether a society is in fact ready to provide the quantity, quality and range of services required to maintain the elderly and other populations at risk in community living. This means, among other things, a much closer look at the needs level being met by existing services, and the kinds of additional inputs required, including training programs, to meet a reasonable proportion of projected future needs. This article examines the British home help service which raises a number of the general issues that have to be faced in other countries as well.

No country is fully satisfied with its present in-home programs, nor with the proportion of the known need now being met. As with other sociomedical services there is a dynamic relationship between demand and supply, in which the former increases with increased provision of the latter, rather than vice versa. This open-ended quality raises the anxiety level of welfare administrators and program planners who fear that, like Alice in Wonderland, the child will suddenly grow tall—and never stop growing.

The anxiety level appears lower in the leading countries, which have faced the fact that these services are necessary and do cost money. In terms of the ratio of home helps per 100,000, Britain is far below the three other leading countries (Sweden, Norway, Netherlands), all of whom have 400 or more, with Sweden having 825. The British goal is to develop home help services two to three times those available in 1967. According to the target established by the Department of Health and Social Security, a local authority "would not be over-providing" if it aimed to have 150 home helps per 100,000 (or 12 per 1,000 elderly) by 1983.

Whether this target is adequate has been seriously questioned by a leading British sociologist, who finds it far too low. After reviewing other available expert estimates, and the most recent data from Greenwich and Crewe, Professor Moseley concludes that a figure of between 300 to 400 would seem to be more appropriate. He considers such a large increase to be highly unlikely, and suggests that alternative policies will have to be re-examined. The least responsible course, he says, would be to ignore the problem.

The need to plan for and implement a substantial expansion of services is one of the many issues faced by the British program which is in a state of transition, battling on many fronts. Transferred by Lord Seebohm's reorganization from the Health to the Social Services Department, the home help organizers found themselves in an alien world, in which the service was expected to continue, but little attention was paid to it. There is evidence that this is changing, although in an uneven way. Meanwhile, local authorities themselves are being reorganized and their areas redefined, along with the National Health Service.

A working party has been studying training needs for organizers of home helps and other supportive domiciliary services for the better part of a year, with an emerging recognition of the unique management and social work roles of the valiant but largely untrained organizers. The management function of a home help, homemaker service, utilizing a large untrained and sizable work force spread over a large geographic area is one which has been underrated in American thinking.

What further schemes may emerge for training the helps themselves is problematical. Although a leading British social worker, Kay Richards, sees them as a new kind of community worker, with a range of potential services to offer, most see them as they have traditionally performed—doing their jobs in a common sense and helpful way, with a minimum of training and supervision.

One advantage of the "Seebohmizing" of the service is that it is being studied increasingly, both on a national and a local basis, and a great deal of information can be culled from British sources. I was able to observe it firsthand during a two-months visit to England, and to study four services, two in London, as well as Sheffield and Coventry, in greater depth. My impression, confirmed by other reports, is that the home help services have not only continued,

in spite of the stresses and strains of reorganization, but have actually expanded in recent years. With increased visibility there is evidence both of increased case finding and more referrals. Moreover, there has been relatively little disturbance of service to previous recipients.

Official statistics of the total cases attended per 1,000 population report that the figure for England and Wales, which was 6.4 in 1959, rose to the 8.8 level in the 1965 to 1968 years, to 9.3 for 1969 and 9.6 for 1970. The comparable ratios for the elderly (per 1,000 population aged 65 and over) are considerably higher and show the same upward trend: 55.4 in 1965; 57.6 in 1968; 60.3 in 1969 and 62.3 in 1970.*

For the numbers of home helps employed, British figures are more precise than those in most countries because part-time labor is shown in terms of whole-time equivalents. Although a majority of organizers and assistant organizers are full-time, the reverse is true for home helps themselves, most of whom are part-time. Between 1965 and 1972 home help staffing in terms of full-time equivalents increased at all three staff levels; a notable increase in home helps, almost 12% occurred between 1971 and 1972, when reorganization was at its height. As of September 1973 the total number of helps employed, both full- and part-time was 78,934.**

There was a corresponding increase in the number of cases in which service was given, from 427,849 in 1969 to 473,883 for 1972. Within the total, elderly cases increased both numerically and percentage-wise; maternity and "other" declined.

Increasing national totals are noteworthy, but tend to conceal considerable variations in the planning and provision of services by different local authorities. Past studies by Bleddyn Davies and others have documented these variations, both for services to the elderly and services for children. Variability has not been reduced by reorganization, and may even have been increased. In the case of home help, defined as a statutory service, which it is the duty of the local authority to provide "on such a scale as is adequate for the needs of the area", the authority remains the ultimate judge of needs and of priorities.

There are also marked differences in planning capability and performance. The deadline of February 28, 1973 set for the submission of 10-year plans was not met by all authorities, who had only a five months lead time from the date of issuance of the DHSS Circular. Those who did meet the deadline did so in different ways, with some employing professional planning firms, others relying on their own staff studies. A comparison of three published plans, involving two inner urban areas and one large county, found the three starting from different bases in 1972 and setting widely different targets for 1982, in relation to DHSS guidelines:

Ratio of Home Helps/100,000 Population

Local authority	*1972*	*1982*
Salford	80	351
Hackney	192	300
Cheshire	61	145
DHSS Guidelines	68.5	150

The first two started from better-than-average bases and set goals which are closer to those suggested by Professor Moseley. The third is under the 1972 figure, and will still be slightly below the guideline suggested for 1982.

Areas completing the planning exercise are more likely to be higher on the provision of home help services than others. This is true of the city of Leicester, whose 10-year plan is notable in pinpointing shortfalls, such as home help. As of November 1971, 2,058 households were served, 89% of whom were aged 65 and over. Minimum planning for 1976 and 1981, adding roughly 10% to account for the waiting list and valid applications not taken on, would call for service to 2,325 households in 1976 and 2,396 in 1981. A more realistic survey of needs is much higher and calls for serving 3,580 in the former year and 3,690 in the latter. On the survey basis, the shortfall would be close to the national average of 50%.

Turning from planning to provision, Manchester may be taken as an example of a city with a strong Social Services

* Department of Health and Social Security, *Health and Personal Social Services Statistics for England*. London (HMSO), 1973, p. 114.

** Figure supplied by Mrs. Sue Fish, Public Relations Officer, Institute of Home Help Organizers.

Department and a leader in planning services for the elderly. A breakdown of the current budget shows that administrative expenses for head and area offices come to 15%. Home help services get 6%, centers for the elderly 4%, and aged persons homes 24%. Similarly, day nurseries for children get 6% (the same as home help), plus 4% for children boarded out and 21% for residential homes for children. Additional expenditures for "other residential homes and centres" are also listed. It is apparent that institutional care both for the elderly and for children, is funded at a higher level than community care.

The total number of home help cases served in Manchester for the year ending 31 March 1974 was 7,101, of which 6,236 were age 65 and over; for the preceding year the comparable figure was 6,180, of which elderly were 5,341. There is also an increase in the number of chronically sick and tuberculosis cases under 65 being served, with a slight increase in the number of problem families, and declines in service to the mentally disordered, maternity and acutely sick. A different breakdown of new cases receiving home help services in the two most recent years shows an increase in illness or disease cases, with a decline in old age or infirmity. If other categories are included (post-operative disorder, blindness, psychological disorder), there may be a reorientation of the service in favor of the chronically sick and handicapped, regardless of age.

Another excellent service is the one in Coventry. This has been chosen for a research project on home help, financed by the Rowntree Trust, which will double the provision of home helps in one area, and then study the impact of the increased supply on the demands and needs of the area. It hopes to demonstrate, not only that there is a considerable unmet need for home help, but that the quality of life may be enhanced and the demand for other social service lessened.

Qualitative Aspects

As the direction of the Coventry study indicates, the qualitative aspects of the service are no less important than the quantitative. Here information is more difficult to come by. Moseley argues, on the basis of his own and other local surveys, that by and large consumers are fairly satisfied with the service they get, and that the frequency, length and timing of visits must be broadly satisfactory. Here he differs with others, who have found considerable dissatisfaction and have been more critical of other aspects of the present service. Audrey Hunt found, for example, that a high proportion of recipients would like more time allotted; the amount of time allocated to frail elderly cases varied from 1–2 to 9–10 hours weekly, depending on the availability of helps rather than recipients' needs. The average of 3 to 4 hours weekly was too low. In addition, home helps were not supposed to do spring cleaning and window cleaning, both of which are particularly difficult for older people. Although the average amount of service to old people is given in a recent government report as 4.5 hours weekly, a leading organizer states that this is "in many cases totally inadequate and is unsufficient to allow the elderly to remain in their own homes."*

Organizers consistently report that many old people do not apply—they have little information, dislike filling out forms, fear having to pay.

Studies of consumer satisfaction/dissatisfaction are less than conclusive, as the recipients of service represent a group favored over their counterparts in the community who are not being served. Studies of recipients omit non-recipients. Non-recipients include people who do not apply, people who are turned down, people who drop out —all expressions of dissatisfaction. English studies suggest that for every older person served, there is a counterpart in the community not being served. The fortunate persons getting some service are biased in favor of wanting the service to continue and hence give positive answers.

A recent pilot study in a London borough to find the views of elderly people referred to the Social Services Department classified their responses as "entirely satisfied", "quite satisfied", "many reservations", "completely dissatisfied". On this basis only half the respondents reported themselves a "fully satisfied"; in the case of home help the proportion was slightly better than half. A third of the group was either completely dissatisfied, or complained that the home help was not able to come at a regular day and time each week.

A more extensive *Age Concern* survey, involving 597 respondents in different local areas found, to their surprise, that 28% of the group were receiving home help services. They estimated that 42% needed this kind of help. Some of the criticism voiced by their respondents were: frequent changes in the help, irregularity in service, more time needed for the disabled, some disabled cases not helped at all, difficulty in paying fees, lack of money to employ domestic help for necessary tasks. These suggest at least some of the qualitative aspects which might merit further study.

* Joan Parker, Chairperson, Institute of Home Help Organisers, quoted in *Age Concern Today*, No. 10, Summer 1974, p. 27.

If one looks for needy cases, one will find them. For example, an action survey in Coventry of elderly needs, conducted in 1973, found that 57% of the elderly people visited were ill or disabled. Of the first 900 cases, 898 were considered to need more assistance. These examples could be replicated by other survey data from British sources.

Aside from consumer satisfaction and survey information, more effective ways are being sought to monitor home help assessments and allocations. A pilot project in the London Borough of Hammersmith reported in February, 1974, initial successes in developing such a scheme. Two previous studies had found that existing clients need more help; their goal was to quantify the extent of the shortfall, and to get more data on the actual division of available time among existing and new clients. They found that three-fourths of all clients, who needed 11 hours or less of help each week were generally getting 5¾ hours or less. They concluded that most people probably need twice as much help as they receive. Both new and reassessed clients need more help; however, there is a tendency for new clients to be assessed as needing less help than existing clients and also to receive less.

My own observations of the British scene convinced me that the home help service is skewed in the direction of providing a little service to many cases at the expense of a more intensive and more meaningful service to some. This is being compensated in part, but not entirely, by the introduction of an additional level of helpers, called by names such as *wardens, family care workers, good neighbors,* who fill in some of the gaps by extra visits and weekend duties. However, in practice, services are further thinned by a crisis-oriented ethos, which gives top priority to emergencies. And emergencies occur every day, either to recipients or staff, or both. For example, when a home help is ill, another will be pulled off her own cases and reassigned. This is rationalized as providing a kind of test of how much some people really need the service. However, it seems to question the validity of the needs assessment process, as well as to play havoc with established relationships with families who are suddenly not being served.

The whole area of needs assessment, by whom and for what purpose, is one requiring further study. If the social worker is uniquely qualified to make a psychosocial diagnosis of the dynamics of family functioning, and the home help organizer is uniquely qualified to assess exactly what kind and how much help a family needs, how do these pieces get put together in an overall plan?

There is another important aspect of the British service which deserves attention, however, and that is the issue of charging fees. Although the bulk of the financing for services is done through the budgeting of local authorities, with some support from the central department, most authorities also charge fees. These are generally low, and almost always below the hourly wage paid to the helper. Many people do not pay at all, in particular those receiving supplementary benefits. It seems apparent that receipts from fees do not begin to cover the cost of the service, and may be dysfunctional in terms of the time and effort expended. In many cases it costs more to pay the salaries of the personnel to collect the money plus administrative costs, than the amount received in fees. Attempts to collect fees also have hidden non-monetary costs in projecting a negative image of a so-called "service" oriented more to bill-collecting than to human needs. English home help organizers find that the existence of a fee schedule acts as a deterrent to applications from needy older people, who fear they can't afford it and don't want to do the paper work involved. (This is consistent with U.S. studies, which consistently find underutilization of available services and entitlements by the elderly, for some of the same reasons.)

A few authorities have gone on a free service, no-fee basis but most have not. It is difficult to get much information on how this has affected expressed demands for service. Fears that a no-fee basis would deluge a service with new referrals have not been borne out. Instead, the same social deterrents which have always kept the number of applications accepted in line with the available supply seem to be operating.

Opinions vary on the desirability of retaining fees. Some feel that the amounts collected are insignificant, but that it is too "political" an issue for most local authorities. Others feel that, even though the existence of a fee schedule may deter some from applying, fees are psychologically valuable, in making recipients feel that they are not charity or welfare cases, but are paying at least part of the costs. Does a recipient have the right to complain about deficiencies in the service? The best professional thinking is that he always has the right, whether he pays or not.

Do old people have other basic rights, including the right to adequate care and attention? If so, home help and other services should be greatly expanded. Otherwise, in the language of the Seebohm report, services for the old in many areas will remain "underdeveloped, limited and patchy".

A VIEW FROM THE FIRING LINE

by

Mrs. Enid Williams*

A British Home Help

I well remember how it was that I first started to work as a home help. We were living in a prefabricated bungalow —the "little flatty houses" as my young daughter called them. We were a very happy community, 14 bungalows in all, all young married people with two children. This was the first real home we had had after the 1939–1945 War. And so it was that one of our neighbours had started to work as home help. She told me all about it, saying how convenient the hours were. At that time we were especially hard-up and I was glad to find a job to earn some money and also to be able to take care of the children with a clear conscience.

That was 23 years ago, but it really doesn't seem that long. From the very beginning I think I realised what a useful job I was doing and I enjoyed helping the aged and infirm. The work is very tiring some days, but there are such a variety of jobs, I cannot ever remember being bored through repetition.

Besides the variety in the actual jobs, the various people we meet are extremely interesting. They come from all walks of life and they all need some help when they are too old or ill to take care of their homes. The doctors and nurses care for their health, but the home helps add that finishing touch, by keeping them all happy in their own homes, which is where they most want to be in their old age.

It is the very old lady or gentleman to whom the home help is a real friend, and to the housebound she is a link with the outside world. She should be patient, tolerant and kindly, three attributes which most home helps have; also she should tackle any job which comes her way.

From time to time lectures are arranged for us to attend. These are designed chiefly for the client's safety, as well as our own. I found these lectures very helpful and learned a great deal, as to how best to wash clothes and to cook meals on very little money. This was very useful for myself as well as for my clients.

We are told from the start that nursing does not come into our duties, but who could see an old incontinent person uncomfortable because the district nurse had been unable, through sheer pressure of work, to come along that day. The home help tackles these jobs often when they arrive to find their old friends so miserable. I would say that the home help just gets on with the job in hand, whether it be housework, shopping, laundry or a few repairs around the house. The client looks forward to the days when "her" home help is coming. Maybe she attends just once a week or even each day as the necessity arises.

It is with real pleasure that I would note that the elderly gentleman to whom I was sent would endeavour to make himself smart when I was due to come to him. He always had a clean collar and tie on. I am sure that he had in the past always looked smart, but this particular gentleman had unfortunately had an accident and had broken his thigh. He was over 80 years of age when this had happened. I first met him when he was sent home from the hospital. He was unable ever to walk outside again, but managed to walk about in the house. He always looked very ill but never once did he complain. His chief worry was his shopping and laundry and of course his weekly pension. The doctor arranged for him to have a wheel-chair, so when I went down to the shops, I would help him into the chair and we would both go shopping. He would carry the shopping bags on his lap and in that way he could see a bit of the changing outside world. He would do his own cooking, as he would say "It gives me something to do". Shopping, laundry and pensions are three of the things which bother most elderly people when they have no relatives living near to help.

I found most clients very easy to get along with. The most difficult to me were the clients who suffered mental stress. Through the very nature of their suffering, one was never really able to satisfy them and no matter what you did for them it was never right. One such client I remember, had grumbled that since she had rheumatism in her hands she had not been able to make a sponge pudding; so hoping to rectify this small point I said I would make it for her and she could steam it for her dinner, as my time would not allow me to cook it as well as make it and do the necessary household chores. All was well until I went the next time and quite naturally asked if she enjoyed her lunch. "Oh

* Mrs. E. Williams was in the New Year Honours List in January, 1972, when she was decorated with the British Empire Medal. The citation spoke of the wonderful work she had done as a Home Help and her most valuable service to the community.

yes", she said, "the pudding was lovely but I can't have another. The kitchen was full of steam and affected my chest."

Another such client was a sad case of alcoholism. She had been used to a far better life than she was enjoying at the time when I first met her. Living in a furnished room, she had stumbled down about three stairs and when I arrived she was sitting bolt upright against the wall at the foot of the stairs. The landlady being a very excitable person had immediately sent for her doctor and given her brandy. What she was not aware of, was that my client was drunk anyway. Somehow I managed to get her on to her feet and literally pushed her upstairs to her own room. I will leave you to imagine what the doctor said when he saw her.

Personal relationships with the ability to reassure clients that you are there to help them is the first duty of a home help, I would say. Of course you are involved in their lives, but I would hasten to add, not to become too involved, so that you have no life of your own. This can so easily happen. You feel such compassion for the sick and lonely, the blind and the deaf; being healthy with all your faculties, you feel you must give generously of your healthy strength to those less fortunate than yourself.

The blind present a different picture of a home help's duty. I would always try to remember to put articles back exactly where I found them. I was not always successful—a point I would be reminded of next time I visited. Also I would keep a running commentary as to what I was doing because I think this reassured them a little.

A very funny story I remember is about a very dear old friend of mine who was very, very deaf and had been issued with a hearing aid which she had a habit of removing unless she was expecting you. Many such times I had gone to her flat for some little thing she had asked for at the shops. When I had got it for her I would call back, probably not on my official day. Of course, I could not make her hear, so would pop a note through her door. When I did go there the next time, at my official time, she would be full of apologies. She had taken her hearing aid off again and had not heard the bell.

When a neighbour had gone visiting one Saturday afternoon, she had got so worried being unable to get Mrs. B. to answer the door, she telephoned the police who very obligingly came and climbed on to the balcony and sure enough Mrs. B. was asleep by the fire. Imagine the confusion when Mrs. B. awoke to see a policeman at the window. All was well, but Mrs. B. was very annoyed with her kind neighbour, who of course had done the right thing, but you could not persuade Mrs. B. that she had; she was really indignant. Now she has a flashing light when someone is at the door which is a much better idea, because she has very good eyesight for her age.

Our organiser prepares a time sheet for us to work by and we are expected to follow the time exactly. If for one reason or another we have to change it, she expects us to let her know. She has a good knowledge of where you might be at any time of the day and you can then be found if she wants to get in touch with you. The organiser and the home helps have a very happy relationship.

When I first started in the home help service, we had as head the medical officer of Health, but now we are slowly being integrated into the new Social Services. In the South London Borough where I work, the social workers are getting to know the home helps and are beginning to realise their value to them in their work.

I always found the doctors in my area very helpful, insomuch if I was worried about one of the clients, I then had a word with the doctor on the telephone and no matter what time of day it was, he would either visit that day, or the next according to the pressures of his work.

I do hope that I have conveyed to you what a rewarding job the home help is. So many elderly people are so grateful for their home help and do not know what they would do without them. The job, though hard, is one of satisfaction in knowing that you have done a good job in helping the elderly and infirm.

One of the most rewarding jobs, I found, was attempting to create some sort of semblance of order out of chaos, because that seems the only way to describe some of the homes we are asked to attend. When you arrive you really don't know where to start, there is so much clutter and dirt. I must add here that through re-housing and rebuilding these cases are few and far between, but we do come across them occasionally. It is quite usual for the client to say "No, I don't want that moved", or "No, that is not dirty." Then you get results if you say how much nicer it will look when washed. You do not get much satisfaction from this kind of home until you have visited quite half a dozen times; then both you and the client can see the difference. They nearly all like clean and tidy homes, it is just that they have not the will or the strength to do their housework and then it gets neglected.

To those ladies anticipating becoming a home help, I would say, by all means apply to the organiser of the area in which you would like to work. Manual work is the operative word and if you are a kind person, willing to work and have a great deal of patience with the aged and sick, then I can assure you that you will enjoy your term of office in the home help service.

THE DEVELOPMENT OF HOME HELP SERVICES IN THE NETHERLANDS

by

Dr. J.M.P. Scholten, Secretary

International Council of Home Help Services

I. Introduction

It is a well-known fact that in almost every country more people are living longer than ever before; the welfare agencies have to deal with the well-being of the aged. This applies to the home help service too. A survey of the issues involved in the home help service in the Netherlands may be interesting for the home help agencies in the other countries.

There are normally many services and activities, directed to help the aged living in their own homes. If the aged are to retain their health and independence, it is important for them to be able to make use of a number of aids and services which society must make available. Some of these are: a sufficient income, suitable housing, home-nursing services, medical advice and treatment, amenities and provisions concerning the field of social and socio-cultural activities for promotion of interpersonal contacts, recreation, information referral service, and assistance with housekeeping, meals and transport.

The aged in need of assistance in many aspects have to be helped by a varied range of services, within easy reach of their homes. One of these services is the home help service, providing primary domestic help, done by specially qualified persons under competent direction.

The specific sphere of action of the home help service is domestic activities and household work, but this domestic work has to be done with a view to the general purpose: to enable the aged to function independently in society in their own homes. It is therefore necessary to cooperate closely and efficiently with other services, having the same general purpose.

II. Background

To understand the issues, it is necessary to give some basic information about the home help service structure in the Netherlands. The home help service, started before 1940 and developed in the ten years after 1945, was organized—not by governmental—but by private organizations. The original and primary purpose was to help families, as essential units of society, and secondly households of individuals, living in their own homes, such as aged and disabled persons.

These private organizations were established by a Christian denominational group, by a denominational group based on humanism, or by a non-denominational group. Originally, great value was laid upon motivation. Therefore, the home help service organizations could be characterized as a kind of charity institution based on personal and humane motivation for helping families and individuals.

Gradually it became clear that this home help service was very important for the well-being of society as a whole, and even necessary. The social importance of the home help service began to be emphasized, and home help service developed as an indispensable part of social welfare activities, with its own image and identity. What had been charity became a profession, done by professionally trained workers who placed great social—and even—economic value on their work.

The recognition of this social value promoted the willingness of the local and national government to support home help services. The first subsidizing rule dated from 1948, and since then has been many times expanded on request of the private organizations.

The number of home help agencies at the local level increased to over 1000 throughout the whole country. In each town or region there were different agencies in accordance with the different denominations. The local home help

agencies, based on one of the different denominations, had their own national organization. As a result, there were six national organizations working together in the Central Board of home help services.

Organization and Training of Home Helps

Each home help service agency was normally composed of a number of board members, one or more organizers and a certain number of home helps.

The board members usually took care of administrative policy and activities with regard to finances, consultation with local authorities, publicity, recruitment and working conditions of the organizers and home helps. They performed those functions as volunteers.

The organizer was charged with the function of supervising the home helps and their work. She also had to visit the client's home, judge the client's request for help, decide who should receive help, allot the time of client's help, and give guidance to each home help on the practical aspects of the job, especially with regard to the untrained, part-time home help for the aged.

The organizer, executing the function of competent direction, was a professionally trained social worker, though a great number of agencies employed a less-qualified person as leader, because of lack of money and/or because of a too small number of home helps employed. The organizer was paid. He or she had a full-time job in giving guidance to 15 full-time home helps.

Home helps were professionally trained (18 months—6 months in one of the 22 training schools for home helps and one year in practice), but most agencies also employed another group of home helps, without professional training, but competent in the field of domestic work. This group of home helps worked both full- and part-time.

By 1969 there were about 1000 home help services, of which: 240 were rather large agencies with 20–60 home helps; 160 were small agencies with 11–15 home helps and one organizer; 600 were very small agencies with 1–10 home helps and one part-time organizer.

These 1000 agencies employed 1150 organizers, ⅓ of whom were professionally trained social workers. In 1966 there were 4370 professionally trained full-time home helps, working for families; 4300 nonprofessionally trained home helps, full-time, working partly for families, partly for the aged; 8000 non-professionally trained home helps working partly for the aged. These helps were mostly middle-aged women. The part-time home helps worked on an average of 15 hours a week. The majority of the aged receiving home help service, received help for 2 to 3 half-days a week.

III. Recent History

Since 1948 the home help service has been continually evolving in order to adapt to the changing situations and circumstances in Dutch society. The current period is characterized by a significant growth in the population of the aged and consequently, the need of more home help service for the aged.

Improving Efficiency by Creating Large Agencies

In the years 1965–1969 there were about 500 home help service agencies (of a total of about 1000) with not more than 1–10 home helps, under the direction of non-professionally trained organizers. Nevertheless, the work of these agencies was of great social value and importance. But in a period where home help services had been developed as an indispensable part of social services, it became clear that small agencies were very vulnerable. Their services ran the risk of discontinuity in the case of illness of the organizer or of home helps while the need for help was increasing enormously.

Three ways of improvement were possible:

1. to combine two or more small agencies established by the same denominational group working in one region (regional enlargement);
2. to combine the home help service with other social welfare agencies (functional enlargement);
3. to combine two or more small home help agencies, working in the same town or region, established by different denominational groups, into one home help service (denominational enlargement).

The application of the first two possibilities had the advantage of maintaining the original denominational character of the organization of the home help service. The application of the third possibility resulted in removing the original denominational structure of home help services.

There were a lot of meetings and discussions about this problem at the local, regional and national levels, but finally the third possibility was adopted because it was the simplest solution. This solution was the best way to maintain the identity of the home help service among the other social services. The result today is that the number of home help services has been reduced from about 1000 (in 1965) to about 400 (in 1972). And the process of consolidation still goes on.

Improving Efficiency Through Better Administration

The promotion of a better administration and staff was the second stage in the development of the structural organization of the home help service.

In order to stimulate the creation of large home help agencies and to promote home help service for the aged, the central government, in close cooperation with the Central Board of Homehelp Service, representing the 6 national private home help agencies, laid down special subsidizing rules for large home help agencies, specially appointed by the authorities. These agencies had to conform to special minimum requirements with regard to:

a staff-composed of a manager (director) and at least one professionally trained social worker as staff-functionary and a certain number of organizers charged with the direct guidance of the home helps. Employment of more staff-functionaries is recommended. Qualified persons are considered expert in the field of education and domestic science;

b the number of home helps—at least 50 home helps must be employed, of whom at least 15 are professionally trained home helps.

These subsidizing rules came into force July 1, 1967 and provided a raising of the subsidy percentage to 90% for the costs of staff, 85% for the costs of the professionally trained home helps and the home helps for the aged, and 80% for the cost of the other nonprofessionally trained home helps. It goes without saying, that this policy is stimulating further efforts in order to reach this "standard" of structural organization and quality and quantity of work.

Currently, there are about 100 large agencies (appointed agencies) with an average of 200–600 home helps (some of them with 400–600, and even a small number with 600–900 home helps). A rapid growth of the number of home helps will be necessary to meet the increase in need of the aged.

Improving Services to the Aging

Experience has shown that about 10% of the aged living in their own homes need domestic help. In order to get some idea of the extent of need of the aged, it is important to pay attention to the absolute number of the aged. For instance in 1969 there were: 1,276,277 elderly people (age 65 and older, 10% of the whole population), of whom about 88% were living in their own home (1,123,127). Taking into account that 43% were married, there were 1,098,980 aged units, of whom about 10% needed domestic help—namely, 109,898. In fact, home help has assisted not more than 48,000 aged units, given the available number of part-time home helps—23,000. Consequently, the home help service would need more than 50,000 part-time home helps in order to meet the needs of the aged completely.* This clearly indicates that the home help service in The Netherlands has to take measures to meet the extent of need in the following years. Such measures are included in the "Memorandum on Care of the Aged—1970" prepared in cooperation with all the private organizations concerned. Concrete measures, planned for the next five years, are:

1. an increase of 45,000 part-time home helps for the aged within five years (9,000 more home helps every year);
2. district nursing services to be expanded by the addition of 1,200 auxiliaries within five years;
3. an annual increase of 50 service centers;
4. the setting up of an advisory committee on the responsibilities of municipal authorities for developing social services for the aged.

* In 1972 the number of part-time home helps had increased to 35,000; in 1973 to 45,000.

The improvement of efficiency and the increasing need of more home helps for the aged charge the home help service on local, as well as on national levels, with the enormous task of solving many existing problems as well as those resulting specially from the enlargement of the agencies and from the necessary increase of home help service for the aged.

First, there is the question regarding the recruitment of a sufficient number of part-time home helps. Home help service appeals continuously to middle-aged women in society. Experience shows that the job of part-time home help is very suitable for them because of the flexible work hours. Married women are able to fit work in while looking after their own homes and families. The job also appears to offer them great personal satisfaction.

Second, there is the question regarding the quality of work and the guidance of the increasing number of part-time home helps. The quality has to be guaranteed by careful selection and introduction to the job, and by planning short courses for orientation (one week). This is a special task for one of the staff functionaries of the large agencies.

The increasing number of part-time home helps presumes a sufficient number of organizers; generally the home help service needs one organizer for every group of full-time home helps, or one for every group of 30–35 part-time home helps.

Third, there is the question regarding their administration. It is, of course, inevitable that the home help agencies with a great number of employees have to be well organized. In the "appointed agencies", a director is charged with the administration of the home help service. The Central Board of Homehelp Services has established standards for working conditions and some standards for the description of the different functions of the staff of the large agencies.

The Central Board informs the agencies about financial matters by periodically providing information about subsidies and salaries, especially for the financial administration of the home help agencies.

Finally, there are many other questions concerning:

1. registration—for that purpose models of registration and administration are used as well as a standard-model for annual reports;
2. research—partial research is made by special questionnaires, but an overall survey is laid down in annual statistics;
3. evaluation—in order to adapt regularly the broad policy to changing situations;
4. improvement of the teaching role of the specialized home helps;
5. establishment of supportive services such as creches, day and night guard, technical teams for solving special technical problems in people's homes;
6. the utility or necessity of "extensiveness" of the work of the professionally trained home helps, by helping more families in one day, especially in order to improve the efficiency in relation to the cost of day help.

IV. Coordination

The home help service for the aged is only one of the services providing ways and means to enable the aged to remain in their own homes and to maintain their independence. Consequently, the home help service has to cooperate with a varied range of services.

An indispensable way of doing this is to take part in the service center for the aged on the local level. A service center involves not merely finding a building, furnishing and engaging staff, but also the enlistment of services and the cooperation of all kinds of organizations such as health organizations, social welfare organizations, associations or clubs (composed of the aged themselves), and professionals (such as practitioners, community-organization workers and representatives of the churches or religious groups). Only this way, will it be possible to create a service center that provides a comprehensive range of services for the aged living in one area of a town or village or district. Such cooperation presumes willingness and respect for one another.

In January, 1970, there were 52 such service centers operating with government grants. Such cooperation has to increase and be stimulated by the home help service on the local and national levels.

HOMEMAKER-HOME HELP SERVICES IN DEVELOPING COUNTRIES

by

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The August 1973 United Nations report "Question of the Elderly and the Aged" highlights the policy issues on aging which developing as well as developed countries face.*

The U.N. report reviews a set of demographic data and projections, some of which are known. In all regions of the world from 1970 to 1980, the rate of increase of the 65-and-over age group will be greater than that of the world's total population, as well as that of any other age group. Over the next three decades there will continue to be an increase in the absolute and relative size of the aging population. What is less well-known is that this trend will accelerate in the majority of the less developed countries. Average life expectancy at birth in these countries, now slightly less than 50 years, will increase on the average by 16 years by the year 2000.**

The implications of these demographic changes for reshaping the age structures of societies are less clear. The policy implications have scarcely been identified, much less studied. Already we see that the breakdown of the family as a unit of production has taken place in many countries, while the movement of population from rural to urban areas has weakened the traditional support system of the joint or extended family group. How is this gap filled?

It is not always filled. Each country tends to develop its own mix of institutional and community facilities. My particular interest is in the extent of in-home services, which statistically appear to be insignificant in non-western countries.

In many of the countries I visited, the idea of *home help, homemaker, in-home services*—by whatever name called —is catching on. It is spreading from the highly organized programs in Scandinavia, Western Europe and Britain to Asia and the Western Pacific, to Africa and the Middle East. It is beginning to spread to Latin America as well.

A spectrum of social services of a wide variety is and will be needed, including a larger output of units of service presently available as well as additional services not now provided. What we do not know is how many, which kinds, where to establish the trade-off between institutional and home-delivered services. We do know, and the U.N. Report reminds us, that in certain western countries (including our own) there is a critical lack of services, facilities and resources to assist the aged. How much more deficient are the developing countries, which start closer to a zero base?

No one knows. To answer the question even in a preliminary fashion requires the definition of categories of need and the specification of standards with a precision few countries have attempted. Statistically, we know something about numbers of institutions and their residents, but very little about home-delivered services. For the Asia-West Pacific region almost nothing is known. There is no comparative data available either from the United Nations, from the Economic Commission for Asia and the Far East, nor from the Bombay regional office of the International Council of Social Welfare.

In any country services for the elderly do not exist in isolation, but are part of a range of institution-based and community-based programs. Looking at existing services, or the beginnings of services, what patterns can we identify? Are there innovative approaches in countries with which we are less familiar, or do these countries tend to imitate Western models of social service programs, as well as economic development?

In order to view home-delivered services as part of a spectrum of services for the elderly, I have been working on a conceptual model, ranging countries along a "residual-institutional continuum," as defined by Wilensky and Lebeaux.† In a "residual" society, an individual's needs are properly met through the family and the private market; only when these break down do social institutions come into play, and then only temporarily. In an "institutional"

* "Question of the Elderly and the Aged: Conditions, needs, and services and suggested guidelines for National Policies and International Action." *Report of the Secretary General*, United Nations, General Assembly A19126, August 28, 1973.

** *Ibid*, Chapter II, 16–27.

† Harold L. Wilensky and Charles N. Lebeaux, *Industrial Society and Social Welfare*, New York (Russell Sage Foundation), 1957.

society, universal social services for all, not just for the poor and disadvantaged, are built-in, permanent or "institutionalized" features of life, for which public responsibility is assumed. I have selected the basic concept of the "residual-institutional continuum" as the most useful for a definition of services to the aged, because it reflects the degree of public responsibility assumed as well as offering a possible fit with the minimum-indicative-maximum standards approach developed in my paper on the status of home help services in developed countries. The current version of my efforts is shown in *Figure 1*.

FIGURE 1

SPECIALIZED SERVICES FOR THE ELDERLY: STAGE OF DEVELOPMENT MODEL

RESIDUAL: Characterized by—

1. family and mutual aid only; some volunteers;
2. some private homes for the aged;
3. no public funding of facilities for the aged;
4. lack of training programs;
5. lack of home help or other domiciliary services.

EARLY INSTITUTIONAL: Characterized by—

1. organized social services, including volunteer organizations;
2. attempt at supervision/regulation of private homes;
3. some public funding of institutions for the aged;
4. professional training programs with an aging component;
5. demonstration home help-domiciliary services.

INDICATIVE INSTITUTIONAL: Characterized by—

1. specialized medical facilities, such as geriatric hospitals; chronic care and attention homes;
2. licensing and regulation of private homes by a public agency;
3. public funding extended to special housing, community centers, and other facilities;
4. substantial development of professional training programs;
5. substantial development of a range of domiciliary services, including home help, meals on wheels, laundry, transportation, and the like.

MAXIMUM INSTITUTIONAL: Characterized by—

1. a range of specialized facilities, including day care centers and hospitals, halfway houses;
2. participation/leadership in regional/international programs for establishing and enforcing standards;
3. active organizations of the aging, political and otherwise;
4. regional centers for research, training and community service in gerontology;
5. a cluster of domiciliary services, coordinated with other health and welfare sub-systems.

Thus, countries may be ranged along a "residual-institutional continuum." At the "residual" end of the scale the self-help, mutual aid, informal network is relied on for all services; some private homes for the aged may exist, but are generally unsupervised and unregulated.

As one proceeds toward "institutional" provision, where public responsibility is accepted for basic social services, there are other patterns of services for the elderly. A model home may be supported, as in Burma, or publicly provided, as in the Philippines and Thailand. A council of social services may assume responsibility for the supervision and rationalization of private homes, as in Singapore, with only token home help services for public families with children.* A great leap forward may be made, as in Hong Kong, where private agencies have pioneered in demonstrating the need for home services, and provision for them is now built into the 5-year social welfare plan. Finally, a well-developed program along Western lines may be found, as in Japan.

Using this model, Indonesia and Afghanistan would be classified as *residual*; the Philippines, Burma, India, Pakistan and Kenya would fall between *residual* and *minimum institutional*; Singapore, Thailand, Iran and Greece as

* Rationalization refers to the establishment and setting up of standards for the operation of such homes. This may also involve the closing of sub-standard homes moving residents to better facilities, the construction of new homes and the training of volunteers and staff.

minimum institutional; Hong Kong is moving from *minimum* to *indicative institutional*. There are more possibilities for specifying positions in between. Looking at the other end of the scale, Australia, Austria and Germany would be *indicative institutional*; Japan, United States, Israel, Netherlands, Great Britain would fall between *indicative* and *maximum institutional*.

This scheme may have some utility as a classification device. It can be used as a checklist; for example, putting an "x" were services are found, or an "o" where none are found. One could also use it with a point or weighing system, which would yield a rough quantitative measure; again, the assignment of weights would require some consensus on standards. Of course, it would be of much greater utility if data were available so as to quantify for each line item the units of service available, and to proceed to a level-of-effort calculation, such as I suggested in looking at *home help ratios*.

This model is not meant to suggest inevitable progress through various stages of development, beginning with residual. It is neither a prescription nor a proscription. In fact, my own travels have convinced me that movement is neither inevitable nor one-directional.

There are three levels of home care, not all of which are found in all places. Home helps everywhere perform a conglomeration of duties, which vary with the climate, living arrangements and time available. Basic housekeeping tasks such as cooking and cleaning are supplemented by shopping, errands, and other chores. Personal care with dress and bathing, such as a family member might perform, is a second major element, although a line is usually drawn between such care and professional nursing services. The third level is best described as educational or counseling, teaching families better methods of home management and helping them with problems of daily living. Whichever levels of care may be provided, the care-giver becomes involved in a personal relationship with the recipient, which is meaningful for both.

In terms of Western programs the third level is usually viewed as an advanced level, requiring special training and skills on the part of the workers. However, this is not necessarily true in developing countries. One of my interesting and unexpected findings is that the educational/counseling component may be present, where direct services do not exist. This was observed in Kenya as well as in Burma and in India, and suggests that a home economics-extension service thrust may serve to build a base on which actual services may later be erected.

On the one hand, it is sobering to find so little in the way of innovative approaches to the worldwide problem of providing community services to supplement traditional family care. Somehow one's fantasies are that less developed countries will have simpler, better ways of coping, which we haven't thought of or may have forgotten. The Wah Fu housing estate in Hong Kong is one of the few examples of such a creative approach.

Is it possible that traditional societies, because of their respect and reverence for the aged, will be able to move more quickly to providing a basic level of community services? Again, I have found little evidence to support this.

On the other hand, one observes striking differences in societies at various stages of modernization in what might be called "levels of consciousness" with regard to the elderly. Many illustrations of the presence or absence of, or changes in the expression of societal concern could be drawn from the countries I have visited. How are "levels of consciousness" raised?

Aging and Modernization*

In small city-states, such as Singapore and Hong Kong, a few concerned social welfare leaders have been able to work through a council of social agencies to raise the level of consciousness. As the case of Hong Kong clearly demonstrated, the creation of a working party on the care of the elderly in the community, the start of home help services, and the provision for more such services in the 5-year social welfare plan are ways of doing this.

However, many countries in the region are besieged by other priorities, such as family planning in Indonesia and political changes in Thailand and Burma. The case of India is in some ways the most tragic. The population pyramid is beginning to bulge at the aging end. The Indian Council on Social Welfare has formed a committee on aging, to coordinate the efforts of its constituent councils. Meanwhile people die on the streets or live precariously in sewer pipes, old tents and makeshift hovels in the capital city of Delhi.

* A more detailed description of the status of home help services in a number of Asian nations is provided in an appendix at the end of this article.

To summarize briefly the present status of services:

The most organized services in the Asia-West Pacific region are those in Japan, which is the only Asian member of the International Council on Homehelp Services. Australia is also a member, and a second Australian Organization, based in Perth, has recently joined the International Council. Both of these countries have all three levels of care.

Services have begun in Hong Kong, led by two private agencies. Singapore has a token service in the Welfare Department, and is giving higher priority to the task of assisting and setting standards for private homes for the aged. The Philippines, Thailand and Burma have gone another route, which begins with the provision of a model home or homes for the aged and destitute, leaving other services to the informal sector. Afghanistan, Pakistan and Indonesia have no visible home-delivered services, but do have private homes for the aged. Voluntary women's groups are trying to organize services in Iran.

How do these services compare with those found in Western industrialized countries? Some are frankly imitative, as in Japan. One of the Hong Kong services is organized on a traditional North American family service agency pattern; the other is based in a settlement house, which has a multipurpose senior center for the low-income aging. Until more work is done in defining the three levels of standards, it is difficult to measure the quality of services. At the present stage of development the quantity is low.

In conclusion, more data is needed. We will never have all of the data we could use in time to make the policy and planning decisions which have to be made now. But we could use a lot more than is currently available, in particular on the definition and delivery of services.

Some of my own preliminary generalizations, on which further work could be done, are:

1. In every society a substantial but unmeasured quantity of services is supplied by families and relatives, supplemented by neighbors, friends, and volunteers;
2. In every society there are some institutions, such as private homes for the aged, used for the homeless and those lacking family support. With few exceptions, there are different kinds of accommodations for those who can afford to pay;
3. The public provision of institutional care generally precedes the public provision of community services, and funding of institutional care tends to be at a higher level at every stage of economic and social development;
4. While lip-service is given to the value of community living for the elderly, home-delivered services to supplement family care are seriously deficient and in most countries available only on a minimal basis.

The Beginning of Services

How does one begin a service? Every existing service started with the idea of one person who perceived a need or had observed a program in another country. The work of volunteers and demonstration projects by private social agencies point the way toward larger programs. The most developed programs have a public welfare base or government funding.

In order to start any program there must be another kind of base, a level of consciousness of the living situations of older people. Building model homes, or supervising and regulating private homes, is only part of the answer. The levels of living of the elderly are part of a massive effort in developing countries to raise the levels of living of people of all ages. Embryonic efforts, representing the first steps of consciousness-raising, and educational programs to change old ways can now be found in some developing countries. A good example is Kenya, which in July 1974 starred as the first African country to host three international social work and social welfare conferences. There are no homemaker-home help services at present but, as a Kenyan expert put it, "The thinking is coming on".

What Kenya does have is a program of home economics education, which operates as a kind of home demonstration or extension service in the Ministry of Agriculture, with participation also by the Ministry of Cooperatives and Social Services. Trained home economists are recruited to work in the rural areas and teach nutrition, child care and household management.* I saw one at work when I observed a so-called "public health safari", actually a kind of "open-air well-baby clinic" near Funyula. After their babies were checked, the mothers (and some grandmothers)

* Three-year programs for full training and one-year programs for assistants are presently available.

sat on the grass and watched the home economist cook a standard maize gruel, adding eggs and vegetables for better nutrition.

What happens when one of these women become ill, is necessarily absent, or is left alone without caretaker relatives? There is no organized in-home service and there is resistance to having a stranger come into the home, especially in rural areas. The solution is to use a relative, friend or neighbor. In this way knowledge and improved practices, learned in the demonstration meetings, spread from family to family. This kind of self-help and rural development pattern, with its strong educational component, may thus be a first step for a developing country.

Burma

A more developed educational program is found in Burma. Here the central department of social welfare is responsible for so-called "homemaker services", which are really training programs, utilizing as instructors social workers, some of whom have received their professional training abroad. The trainees are selected by village officials from among local volunteers known to them, especially middle-aged women. The courses are short, ranging from one to three months, and stress home economics skills. In turn, these trained homemakers are expected to instruct the other women of the village. They do not offer direct services, but are available for short-term family counseling and referral to other community resources.

India

This kind of educational-counseling homemaker role also has similarities to that of the so-called "social worker" in an Indian village, or to some of the volunteer village projects in India, which bring in female university students to instruct the women in subjects like sewing and child care. In India, as in Burma, some counseling may be involved, but the educational component is separated from the actual delivery of services. Emphasis is placed on better methods of nutrition and child care, with only incidental attention to the care of the elderly.

With limited resources for starting new programs, many persons in developing countries show ambivalence about the role of the extended family: it is needed and relied on, but may not be really adequate. Just as in more developed countries, family gaps and destitution provoke an automatic knee-jerk response in many governments towards institutionalization in any institution available.

In almost every country I visited I was told by some one, "We don't have the same problems you do, because the joint (or extended) family takes care of its own." Underneath this kind of lofty statement is a denial of reality, such as the tensions and problems which have always characterized joint arrangements, now considerably accerbated by social change. In every country the young and economically active are moving from rural to urban areas, leaving behind older members to manage as they can. In other instances, the institution of the extended family is still visible and working. For example, in Kenya I visited a village where a man who had been absent 20 years had died in Nairobi; his body was brought back for proper burial and his widow and five children joined an already extended low-income family headed by two disabled adults. Similarly, in India near Bombay, a family, whose father was fortunate enough to be employed, fed not only its own members, but various older relatives described as "uncles" and "aunts".

In the absence of social insurance coverage, the first line of attack in a new country may well focus on preserving and enhancing traditional networks of mutual aid and family support. For example, the Kenya type of home economics education, now directed mainly to the care and feeding of children could add the care and feeding of older people. The most direct way to start this would be to revise the curriculum of the present 1- and 3-year training programs for home economists and assistants, adding course material on aging. Initially, foreign consultants could be imported; some local people could be sent abroad for training. This would have to be accompanied by broader programs to raise levels of consciousness about the needs of older people. If the old are truly loved and respected, as we are told, consciousness raising should be less difficult than in a more modernized society.

In terms of home care and home-delivered services, the fact that newer countries are typically short of hospitals and trained medical personnel, as well as organized social services means that home services may be the only ones available, as well as the most cost-effective. For industrialized countries like the United States, with high and rising hospital costs, one can argue that there are manifest dollar savings to be made in expanding home care. Even though the standard of home care varies, and may well be below hospital care in some respects, there are other benefits to be realized, such as personal care and devotion, the presence of loved ones, familiar atmosphere and surroundings.

These same factors apply to less developed countries which have fewer options. A real calculation of the disbenefits of the joint family has never been made—e.g., the multiplication of intergenerational tensions; the degradation of daughters-in-laws; the domineering of the wealthy and powerful old; the acceptance of early death or near-death for the poor and feeble old. To this must be added the kinds of human suffering involved in all countries when people are "put away" unnecessarily or prematurely in homes for the aged. These are the realities of a true cost-benefit equation.

Accepting these realities, there are small interventions which would yield large payoffs, at least initially. One would be to train a small group of community workers in the kinds of crisis intervention and mental health consultation techniques, which have been developed by Dr. Gerald Caplan and others. This is a way of using a few professionals sparingly for time-limited and largely indirect services, relying on the support systems and informal care-giving arrangements found in the community. If traditional systems have eroded, it would be a community development—community organization task to revive and strengthen them. This could best be done by local people with added training, and the ongoing services of consultants, who would also perform an educational function. Here the public health-community mental health model is more relevant than a traditional social services model.

The western countries, especially the Anglo-Saxon and European, have historically relied on volunteers to come forward, to define a need and to start a pioneer or demonstration project. This is still possible in city states like Hong Kong and Singapore, but for many developing societies a new program may have to be government-initiated. Again, one would have to start with training and education inputs for the organizers and consultants; program planning and budgeting involving different departments, such as Social Welfare, Agriculture, Education. These are costs, against which must be weighed the large potential benefits in strengthening family life, and in improving the living conditions of many people, including older people. Another benefit, which is usually overlooked, is that of drawing into new service programs women whose labor force participation might otherwise be marginal or lacking. From a long-run point of view, the possibility of adding to gross national product by the successful employment of wives and mothers would be a substantial benefit to the economy as well as to the individuals involved.

Looking at home help services around the world, part-time labor, permitting the woman to continue her own household responsibilities, is the rule. Rates of pay are low. Initially most countries have not underwritten substantial training programs, but have relied on brief orientation and limited in-service training to supplement the natural attributes of the labor force. It has also been found more satisfactory, especially in rural areas, to use workers who have the same characteristics as the clients, thus minimizing the entry problem. The first goal should be, then, to recruit a labor force with these attributes, and by a combination of brief training, regular pay (even if low) and job satisfaction encourage them to be stable and committed. This is less difficult than it sounds, as the persons recruited are usually those motivated by the desire to be a helping person. As I have seen in the British and Israeli programs, they are deeply devoted to the care and support of the old.

Japan is a good example of a program which started essentially in a government department. The problem of starting is essentially no different from starting under other auspices. The presence of a worker who has travelled abroad or attended an international conference helps. If there is no such person, sending some one abroad with a specific assignment would be a good investment. Even a brief visit to another country is sufficient to light the spark. No program starts on a large scale. In fact, a visit abroad should help to dispel the mystique that surrounds existing services in more developed countries; they were all started on a mini-scale by one or two persons with an idea but often with limited or no financial resources.

How to do it? One doesn't need a building, an office, a large infrastructure. Use a local government station or community development office for space; a local official or development officer for man- or woman-power. Begin where the people are. Have a meeting in the village of interested people; get a wide representation from local families and clans, being sensitive to tribal and other lines. Elect a chairperson, and an assistant. Decide on what kinds of help are most needed. Make a list of people who need help, and match it with a list of the times and frequency when persons who can help are available. Have regular meetings and group discussions of the situations being dealt with. Use existing workers to recruit additional ones. As a service builds up and a labor force is recruited, a common method of funding is by contract or purchase of service arrangements with local governments. But first the value of the service needs to be demonstrated by actual performance, visible to the community.

By its very nature a home-delivered service fits the cultural, social and communications arrangements of the society where it is found. If people walk, the service will be on foot. If communication is informal, by word of mouth, so

will the services be arranged. In fact, one could predict that delivery might be more direct and more effective than in those complicated and sophisticated programs which interpose eligibility requirements and waiting lists between those in need of help and those who are there to help.

Unless services are started, and allowed to grow, developing countries run the risk of repeating some of the least useful chapters in Western social welfare history: putting the aged and destitute away in inadequate, often substandard institutions; failing to organize programs which could support willing but hard-pressed families in their efforts to cope with difficult situations. There is no real difference in the potential love and respect which exists for a person of any age. What is different are the living circumstances in which people find themselves. Research in advanced countries consistently finds substantial networks of interaction between aged persons and their relatives, even when living separately. We also find many families caught in what the economist Kenneth Boulding has called "sacrifice traps", attempting to care for an ill or disabled older person with few or no community supports. Here again there are disbenefits; loss of time from work; sacrifice of recreation; increased tension and problems of mental and physical health. If developing countries can avoid some of these negative consequences, or disbenefits by the provision of basic home-delivered services, this too may well be viewed as a positive gain. There is no logical reason why a new country cannot make a fresh start, and avoid repeating familiar and dehumanizing Western cycles of relief.

APPENDIX

The following are summaries of the status of care for the aged in a number of Asian countries, where the pattern seems to be first to provide institutional care for the more destitute, followed by a range of services, including home help, as a nation becomes more wealthy and sophisticated in social service concepts.

Afghanistan

There may be countries as under-developed as Afghanistan, but few cities like Kabul, ringed by ancient snow-covered mountains which have seen many conquerors come and go. Efforts at modernization are visible, such as a new program to direct vehicle and pedestrian traffic, or announced plans to activate a network of rural health services. Can social services be far behind?—Yes indeed, very far. Needs for such services are not articulated, and basic data is lacking, in particular census data. The population of the country is not known even approximately. Ten years ago it was thought to be about 9 million; current guesses range from 15 to 17 million. It follows that there are no figures on the number of aged persons, their sex, residence, etc. Hard labor in a cold climate shortens lives, and ages others prematurely. Persons interviewed have only a rough idea of their approximate ages, as the method of reckoning ages varies. Interestingly, some census data is now being developed as part of a WHO project conducted by the State University of New York which, over a three-year period, has trained local interviewers, and identified statistically significant samples both of the nomadic and non-nomadic populations. When their data is analyzed, it should be possible to begin to identify the population at risk.

Indonesia

Like other countries in the Asia-West Pacific region, Indonesia is wrestling with mammoth problems of economic development and population control, with scanty resources of trained manpower. Traditional institutions, such as the joint family and the Muslim church, are residual in functioning.

A high rate of unemployment has accompanied the immigration of large numbers of people from rural to urban areas, which lack housing, sanitation and services. Many old people beg in the streets, or can be seen scavenging in open trash and garbage heaps. The more fortunate are marginally employed, selling food and other small items in the street markets. A few live in church-related homes of varying standards. Those with property or other wealth are able to manage better living arrangements, especially in rural areas. There is as yet no defined area of public responsibility for the care of the aged.

In less developed countries the groups first provided with fringe benefits, such as pensions and health insurance, are the government employees. Here too, Indonesia is in the early stages. Although the health insurance and medical benefits scheme for such employees celebrated its fifth anniversary early in 1973, whatever benefits may be available

are little understood, and in rural areas often not available at all. A technical difficulty is the fact that the number of persons employed by various levels of government is not precisely known, and steps are being taken to register those now employed, in order to make the scheme operational.

Burma

Some public responsibility is accepted. There is a model home for the aged and also one or two in the Rangoon area. This does not mean public financing; in fact, it is stressed that regular gifts by private donors will earn them merit according to the precepts of the Buddhist religion. The home does receive some public financial support, in particular, the payment of the Director's salary. The Director is an experienced social welfare administrator. As in the Philippines and Thailand, the residents of the home include many persons who are able-bodied and who could live in the community with family and other supports. It is one of the few homes which recognizes that not all who enter adjust well, and permits egress as well as ingress.

The Philippines

Home help-homemaker services are virtually non-existent in the Philippines. Neither the British nor the American term is familiar to social workers employed by the Welfare Department.

One reason for this is that the cost of a maid or household helper is still low. Even now in Manila, I am told, it is still possible to get a live-in person for 70 pesos, or the equivalent of about $10 (U.S.) monthly. Not only foreign residents, but many Filipino families, especially where the adults are all employed outside the home, have one or two servants as part of the household. This situation reflects the present low-wage structure and the need for further economic development in order to permit the articulation of social goals for families, as well as for the aged, needing services.

The problem of the indigent elderly is recognized, and some provision made. In Greater Manila I visited both a model national home for the aged, and a city welfare home, both directed by training social workers. There is more awareness than in many countries of the kinds of inter-generational tensions which make joint family living difficult. It is also possible for an older person of means to finance other living arrangements, such as boarding in a hospital. An older person without means may be cared for in the same hospital, in a dormitory with others similarly situated. Thus the only visible services are limited institutional services. Efforts to start old-age clubs and centers have not been successful.

Thailand

If the existence of an active council of social welfare is a clue to possible development of home help services, then Thailand is a candidate. Other issues have had priority, in particular the political reorganization and constitution-making following the October 1973 student "revolution". In this situation, the raising of funds for social welfare programs from private sources, in particular the American device of the so-called "community chest", has been a divisive issue which split the social welfare community.

How many persons receive care in traditional Buddhist homes? Exact figures are not available. Nor is there much information on the living and housing arrangements for the aged in rural and urban areas. The gap between visible needs and present provision has been recognized by a national program of six public homes for the aged located in different parts of the country. The model home is that in the Bangkok area. It is well-administered and includes several levels of accommodation, according to income. A particularly interesting device is the building of small separate dwellings on the grounds, following a prescribed plan; upon the death of the original occupants, these then become available for other old people. Also noteworthy, from the standpoint of standards, is the presence of a small social work staff, as well as the employment of two American-trained professional social workers in the department of social welfare, both concerned with the administration of programs for the aging.

In a benign institution, such as the one in Bangkok, many able-bodied aged live in an age-segregated community, although in close proximity to the outside community, which they may visit freely. Some busy themselves with needlework and small money-making projects; the most ingenious is the old lady who, as the visitor crosses the footbridge over the fish pond, suddenly appears—selling popcorn to feed to the fish. The majority of the residents would not require institutional care if there were housing and a modicum of services available in the community.

Singapore

Singapore invites comparisons with Hong Kong—a city state with a large Chinese population, trying to cope with population planning and major housing needs. But there are also differences—political independence; a large non-Chinese population, including Malays, Indians, some whites. As in Hong Kong, there is a well-organized Council of Social Services, with some professional staff, working closely with both the public and private sectors, as well as with university training programs.

In the network of traditional private social services, no agency has yet initiated a home help program, demonstration or otherwise. The overwhelming Singapore concern has been, rather, with institution-building for the aged, preceded by private institution rationalization. As in every country there are traditional homes for the aged. However, many fail to meet modern standards of public health and cleanliness. For example, the so-called Chinese "Houses of Death" in Sago Lane have been closed.

In response to community criticism of conditions in certain private homes for the aged, a working committee of the Singapore Council of Social Services has taken the responsibility of overseeing these homes and offering them consultation and other services. As a result, one home was closed and the residents transferred elsewhere. With the Salvation Army, The Council worked out an imaginative plan, whereby a former children's home was remodeled into a home for aged women. There are further plans for doubling its capacity, as well as for building a modern chronic care facility. Work with existing private homes continues. Some are under-financed and need more staff as well as volunteers. The desirability of housing able-bodied aged of varied ethnic backgrounds speaking different languages in dormitory arrangements with other homeless persons may well be questioned.

What about home help services to help fill the gap and maintain aged persons in the community? They do not exist at present, but one could predict that they will be started in the near future, because of the visible public concern about keeping the city "clean and green", without beggers. It is unacceptable that old people be homeless or found wandering in the streets. The only program at present is a token public welfare program designed to keep together families with children. This has received little funding and has no personnel.

Could home help services be financed, at least initially, from the private sector? Here there are possibilities in that internationally-based business firms with Singapore offices are more accustomed to western patterns of fund-raising. Other businesses may still prefer the established Singapore pattern of special fund-raising days for worthy causes, by permit. If sponsored by the Council, a fund-raising effort for home help would probably succeed in getting a demonstration project started.

Hong Kong

Hong Kong is a microcosm, in which many social problems are being dealt with simultaneously. In fact, it may be a particularly rational microcosm because policies have been specified and priorities set in a 5-year social welfare plan for the years 1973–1978.* The plan includes specific provision for care of the elderly, following the recommendations of a working party.** Planning and coordinating activities continue, under the aegis of the Hong Kong Council of Social Services. In this planning process the need for home help services (which presently exist on a small scale) has been recognized, and provision made for their expansion in the later phases of the plan.

As we have observed in other societies, there is a trade-off between institutional and community services. The acute shortage of housing space has stimulated some innovative approaches, such as the Wah Fu housing estate where, in the midst of a high-rise complex housing 50,000 persons, parts of two floors set aside for old people, are under a warden's supervision. Here they remain a community within a larger community, and are helped by neighbors, as well as by the staff, to continue in this sheltered setting even when they become very frail.

Less well situated are the homeless elderly, some of whom have found places in the 22 private homes in the Hong Kong area, whose facilities vary considerably. Many families lack bed-space for their own elderly relatives, and those old persons whose family ties have been broken by war and migration are fortunate if they can rent a bed-space elsewhere. The recent provision of a special infirmity allowances for those aged 75 and over, as part of

* For an excellent account of the plan and the process, see T. S. Heppell and Paul R. Webb, "Planning Social Welfare: The Hong Kong Experience", *International Social Work*, XVI, 4 (1973), 16–26.

** "Care in the Community: The Right Basis for Services to the Elderly", *Report by Working Party on the Future Needs of the Elderly*. Hong Kong (J. R. Lee), 1973. Also available in summary form.

the public assistance scheme, helps some to continue a precarious existence in the community. But what of those aged 60 to 75 who are also in need?

In this milieu, private agencies have performed one of their traditional roles—demonstrating the need for and function of the service, in this case home help service. Different approaches have been tried. The Hong Kong Family Welfare Society has taken a family life education approach, strongly resembling North American family service patterns of the 1950's. A major objective has been to try to build a stable labor-force, which to date is mostly part-time. This level of service, in a situation of extreme need, indicates one way in which professional staff can be used to motivate and supervise a new group of helpers, postponing training until later. Financed since its inception in 1972 from the Lotteries Fund, the service now seeks public financial support in order to continue and to expand.*

A somewhat different approach to home help in Hong Kong has been taken by the St. James Settlement, which is a community-center program, serving a variety of age groups and special needs, including the mentally retarded. The needs of the elderly have been especially recognized, and a day center provided where meals are served, outings are organized, and some social work and physical therapy services are available. In this way the settlement workers have become familiar with the living situations of many aged persons, frequently indigent, who need home help services. At first, these were given by volunteers some of whom were young mothers living in the settlement. But the needs were so great that the settlement director has developed an organized program which regularly employs 2 full-time and some part-time helps and serves 15 to 20 clients or households daily.

Japan

The level of home help services in any country reflects the basic legislative, administrative and financial provisions made for a range of services to the elderly, including institutional. In all these areas, the Japanese have made notable advances in recent years, and in fact, are the only Asian participants in the International Council of Homehelp Services.

Home help was first introduced in Japan in 1958, in Nagana prefecture, by a local welfare officer who had observed it in England. The next year, a service was started in Osaka by a Japanese who had been in the United States. The British model appears to predominate, e.g., the term "home help" is the one usually used by Japanese.

For the past ten years the program has been subsidized, and is presently covered by the established Japanese formula for sharing financial responsibility: one-third by the central government; one-third by the provincial government; and one-third by the municipality. Home helpers are salaried employees of a local welfare department, who report daily to the welfare office, and receive assignments and administrative supervision from a social worker, usually the one in charge of services to the aged.** The standard salary paid in late 1973 was 45,000 ¥ monthly (just above the minimum wage). The service usually consists of two visits weekly of one half day each. However, only those whose income is below the level required to pay national income tax may apply. Those who pay income tax are referred to commercial or proprietary services, charging on the average 2,500 ¥ daily.

For the month of June 1973, the number of households receiving some service was 18,897, of which 8,219 (slightly more than two-fifths) were also receiving public assistance. Following the British and Swedish example, the largest number of home help workers is assigned to the elderly. For this same month, out of a total of 9,220 helpers: 7,060 were assigned to older people; 1,193 to handicapped adults; and 967 to handicapped children. Two-thirds of those served received help twice weekly for a half day; the other one-third received four half days of service weekly.**

Who delivers the service? As of the end of 1973, 77.6% of the workers were full-time and 22.4% part-time.† Some volunteers (Minseein) are also used to supplement paid services, as well as in case-finding. The usual paid worker is a middle-aged woman. In Tokyo there is an upper age limit of 45; in other parts of the country no age is specified. The actual average age at the time I was there was given as 46.8 years.

The helper is not required to have had prior training or certification, although some orientation and in-service training is done, and more is planned in future. Instead of professional-like training programs, the emphasis is

* The Yang Social Service Center has also been interested in developing home help services, as part of a team approach to community development, but is presently focusing on the related need for community nursing.

** Not necessarily a trained worker; may be a high school graduate who has qualified by passing a civil service examination.

† Figures supplied by Mikio Mori, Ministry of Health and Welfare, Tokyo.

‡ Future plans call for a shift to a preponderance of part-time.

placed on recruiting persons of desirable personal characteristics, such as "warm", "healthy". All are literate and assumed to be personally familiar with the Japanese mode of living from their own life experiences. Over three-fifths have had a primary school education, and another one-third have completed secondary school. Almost half (44.4%) have had some kind of additional training, e.g., as nurse-midwives, teachers, day nursery aides, or nutritionists.

The services given center around housekeeping, meal preparation and shopping. Escort services, such as accompanying an older or disabled person to a clinic, are frequent and time-consuming. In addition to their pay, the workers may be supplied with bicycles for personal transportation, work clothing and shoes, equipment for nail and hair cutting, and the like.

In a typical Tokyo welfare district which I visited in November 1973, the social worker for the aged had a caseload of 70, many of whom were being seen for family counseling on a short-time basis. There were 28 cases receiving home help, 25 of whom were either an older married couple or an old person living alone; the other 3 all had relatives who worked. There was no waiting list for home help at that time.

The pattern of service was similar in the city of Hiroshima. The city welfare department then employed a total of 99 home helpers, who on the average handled 6 cases, visiting each for two half days per week. The work of the paid employees is supplemented by 990 "friendly visitors" who have volunteered to work with the aged; each visits some 10 households, but performs no home duties.

The level of services available in Japan far exceeds that in any other country in this region. In terms of numbers of home help employed, Japan ranks seventh internationally, after Great Britain, Sweden, the United States, the Netherlands, Norway and West Germany. In terms of the ratio of home help per 100,000 population Japan ranks about twelfth, tied with Israel.

THE HOMEMAKER AND THE ELDERLY*

The greatest socio-medical phenomenon of today is our aging population. Some authorities say it will have greater impact on our world civilization than the industrial revolution. People are living longer than at any time before in the history of the human race. The medical sciences have extended the life span, but society has not kept pace to make this a positive experience for most very old people. As life is extended, close human contacts become fewer, for loved ones move away or die, physical and mental capacities decline, finances dwindle, fears and loneliness increase. Few persons over 65 are free from all of the problems of the aging.

I. Our Aging Population (U.S.)

A. Life expectancy

1. Today, if a person lives to be 65 in reasonably good health, he can expect 14 to 20 more years of life.
2. Women outlive men by about 5 years.
3. One person in 12 in our country is 65 or over now.
4. It is estimated that by 1975 there will be as many people 65 and over in our population as persons 15 years and younger.

B. The changing morbidity picture

1. Great progress has been made in the control of childhood diseases (diphtheria, scarlet fever, polio, etc.).
2. Infant mortality has been reduced.
3. The medical challenge of today and the future is chronic illness (heart disease, arthritis, cancer, etc.). Chronic illness puts more people on relief at the taxpayers' expense than any other cause.

C. Chronic illness and aging

1. "Although the problems of chronic illness and those of aging and the aged are not identical, the two areas overlap extensively. Aging in itself does not necessarily imply chronic illness; but most of the disablement, misery, and uselessness of those past the so-called prime of life are consequent to chronic, progressive disease, and not to age alone."**
2. Reduced ability to get around without help, less acute hearing, failing vision, make one feel and act infirm. These changes come to most people in their 80's or 90's. They may not be ill, but their capacity to manage alone is seriously restricted.

II. When is a Person "Old"?

A. It cannot be definitely stated at what time in life people become old, for age is more a matter of physical and mental aging than it is of chronology. Tremendous variations exist—some people are physically and mentally old at 35, others are young at 65.

B. The words "aging" and "aged" should be clarified: aging is a process which begins with conception and ends with death. Aged means old. But old age is relative, depending not only on the individual's state of health, his feelings about himself and others, and his interests, but also on factors outside of him—such as where and how he lives, whether he has someone interested in him and able to do things for him occasionally, and whether his income meets his needs.

III. Preparation for Aging

The earlier in life a start is made in preparation for aging, the more productive the effort will be.
Factors that lead to healthy aging:

A. Proper nutrition.

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** Edward J. Stieglitz, JAMA, Oct. 4, 1952.

B. Prevention of chronic illness insofar as possible through regular medical examinations.
C. Care and rehabilitation of the chronically sick or disabled.
D. Mental hygiene, which includes an appropriate balance between work and rest, exercise and play; and a spiritual perspective.

IV. Basic Needs of the Aged

Many who have studied the needs of old people, as well as the needs of society as a whole, believe that aged people should stay as long as possible in their own homes. Even when chronically ill, they may do well at home with help.

Basic needs:

A. A quiet, cheerful place to live.
B. A nutritious diet.
C. Something to do that they like to do.
D. Someone to care.

V. The Aging Process

A. Physical

1. General slowing up of the metabolic processes.
2. Rheumatism (mild joint deterioration).
3. Slower reflexes.
4. Poor circulation (cold feet and hands).
5. Change in eye muscle accommodation, and visual defects, such as those caused by glaucoma or cataracts.
6. Hearing loss.
7. Skin changes (drier and less sensitive).
8. Balance less secure.
9. Loss of teeth.
10. Circulatory changes (thickening of artery walls; pneumonia—proneness).
11. Tired heart muscles (exertion affects breathing, heart beat, etc.).

B. Mental

1. Changes in brain tissue due to changes in circulation.
2. Blood vessel spasms.
3. Memory lapses.
4. Irritability due to arteriosclerotic changes (hardening of arteries).

C. Emotional

1. Sense of inadequacy, due in part to loss of importance to anyone, lack of routine, inability to adjust to reduced income, strain of trying to carry on former activities such as getting out to evening affairs, or doing physical work for several hours without fatigue; no longer needed in job, or by family; associates have died; physical slowing up.
2. Fear of future: threat of having to leave home; inability to accept change.
3. Lack of motivation: no driving force to accomplish things.
4. Need for status; of being a person of stature to self as well as to others.

VI. Homemaker Service

Comes into the picture at the point of special need and may be given full-time or part-time, temporarily or on an indefinite basis.

A. Temporary—in acute illness or a temporary crisis created by a chronic illness, or by the absence of the member of the family who usually carries responsibility for the aged person.
B. Indefinite—an elderly person is awaiting admission to a nursing home, a hospital, or other institution; or a person or couple wishes to remain at home but is not able to maintain the home alone.

C. Long-term—in chronic illness where the patient is not expected to recover but the time of change to nursing care or institutionalization is not predictable.

VII. Responsibilities and Contributions of a Homemaker

A. Physical factors of special importance for the elderly:

1. Safety: Remember poor balance, slowed-up reflexes. Hazards include light cords, scatter rugs, untied shoe laces, inadequate lighting, gas burners, matches, smoking in bed, waxed linoleum, etc.
2. Steps can be saved the older person by having a small bag or basket to hold such articles as eye glasses, tissues, sewing, books, etc.
3. Because of poor circulation the house or room may need to be warmer than you prefer; older persons need to wear more clothing to keep warm; drafts should be avoided by use of indirect ventilation.
4. Skin care—frequent bathing of older people may cause excessive dryness of the skin with ensuing itching and discomfort. The use of an inexpensive lotion, such as baby oil, daily on feet, legs, arms, neck, even the trunk, reduces itching and adds greatly to comfort.
5. The heart—avoid undue exercise or hurry. Older people are slow in their movements and thoughts; they must not be hurried, especially in the morning when it takes them longer to "get going". Promote in the client the habit of standing still with hand on chair or other support, for a minute or two after rising from bed or chair, to prevent dizziness and possible fall.
6. A comfortable chair, with support for back of head, a table nearby to hold glasses, pencil, notepaper, and other frequently needed articles, and big enough for a glass of milk or a snack, adds comfort and independence. Some people want a foot rest of some kind, which can be improvised.
7. Encourage changes in position often. Help the older person to go to the bathroom, or to the table for meals rather than bringing things to him, as long as possible. Help him dress, rather than dress him. Unless we use our bodies and minds as fully as possible, we lose mental and physical capacities.

B. Nutrition is the key to many ailments

1. Proper food eaten regularly can not only build up the person physically, but helps to build a better spirit and drive away depression.
2. Older people, living alone, may skip proper meals until they are weak, dizzy, fearful.
3. Often serving the main meal in the middle of the day, rather than at night, is the answer.
4. Sometimes several small meals a day are better than one or two large ones.
5. Soft foods may be indicated if the teeth are poor, to prevent indigestion from improper chewing.

C. Mental deterioration—faulty memory, confusion, irritability

1. Avoid accepting gifts; the donor may forget he gave them away and think someone stole them. (A Homemaker is not permitted to accept any gift from the family she is serving.)
2. Overlook confused statements and irritability; agree and avoid arguments.
3. Often going along with his train of thought will calm the elderly person and give a feeling of friendliness.
4. Be willing to listen to "ofttold tales".

D. Emotional Needs

1. The Homemaker is perhaps "the person who cares"—the only person to give T.L.C. (tender loving care).
2. Often the Homemaker is in the delicate position of helping people who are physically and emotionally dependent upon her, but who need to retain whatever capacity they have for caring for themselves.
3. Never show impatience with slowness.
4. Accept the patterns already established by years of habit; be careful in introducing something new. Usually there is difficulty in accepting change.
5. The older person is often shy. He may be painfully conscious of his infirmities. Respect privacy; knock on a closed door before entering.
6. Respect human dignity—no one wants to be bossed or jocularly addressed as "Granny" or "Pop".

7. Do not disturb personal effects without permission, such as stacks of magazines, papers, boxes. Be careful what you throw out, if anything. Remember as we get older our ideas change as to what is orderly and neat and important to us.
8. Because of the changes that occur with growing older, it is hard to please the older person completely or for more than a brief period of time. The Homemaker must feel satisfied if she has done her best. It can be frustrating and discouraging to be with older people long. But it can also be the most rewarding job if the Homemaker really likes the older person, respects him, and finds some fun in the job.

E. Determining and expanding interests

Many elderly people need to be encouraged to become interested in other things—reading, knitting, bird watching. The Homemaker can be very helpful in finding out their interests or introducing possible interests and activities.

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